PATIENT INFORMATION (Please Print Clearly)

Patient Name (Full):_____ Date: _____

Address:_____City:_____State:____Zip:_____

Birthdate:_____ EMAIL:_____

Date of Injury:_____ **Date of Surgery**_____

Cell phone:_____ Home Phone:_____Work Phone:_____

Sex: M F Marital Status: (circle one) Single Married Widowed Divorced Separated

Social Security #:_____Occupation:_____

Employer_____

Employer Address:_____City:_____State:____Zip:_____

Referring M.D.:_____Primary Care M.D.:_____

Next Appointment Date:_____Next Appointment_____

FINANCIALLY RESPONSIBLE PERSON (spouse or parent's business that provide the insurance)

Insured:_____ Relationship: _____

Address:_____City:_____State:____Zip:_____

Home Phone:_____Work Phone:_____Birthdate:_____

Employer_____

Employer Address:_____City:_____State:____Zip:_____

Other person to notify in emergency:_____Phone:_____

MEDICAL INSURANCE COVERAGE

Primary Insurance Company and Billing Address:_____

_____

ID/Policy #:_____Group #/Name:_____Subscriber:_____

Secondary Insurance Company and Billing Address:_____

_____

ID/Policy #:_____Group #/Name:_____Subscriber:_____

Workman's Comp. Insurance Company and Billing Address:_____

_____

Employer:_____Claim #:_____Date of Injury:_____

Claims Adjuster:_____Phone:_____

ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL INFORMATION: *(Please read and sign)*

I hereby authorize payment of medical benefits to ORLAND PHYSICAL THERAPY & SPORTS MEDICINE, for services rendered to my dependents or myself. I also authorize the release of any medical information that is necessary to process Medicare and/or insurance claims. I understand that I am responsible for any amount not covered by insurance. I understand that a copy or facsimile of this authorization can be used in place of the original. This assignment will remain in effect until revoked by me in writing.

Patient Signature:_____ Date:_____

Signature of parent if patient is a minor:_____

Name:_____Age:_____Date:_____Right/Left Handed (circle one)

Medications (all prescription and non-prescription, include doses):

Surgeries:_____

Imaging, X-rays, MRI, CT (specify by name, dates and results if known):_____

_____

PAST MEDICAL HISTORY

LUNG

□ Asthma □ Bronchiectasis □ Tuberculosis □ Pain with deep breath
□ Pneumothorax □ Hoarseness □ Lung disease
□ Other:_____

HEART

□ Heart attack □ Angina □ Valve disorder □ Arrhythmia (fast or slow)
□ Cardiac arrest □ Pacemaker □ Implantable defribillator □ Cardiac Hypertrophy
□ Myocarditis □ Heart transplant □ Congestive heart failure □ Chest, arm, jaw pain with exercise
□ Fainting □ Palpitations □ Bypass surgery
□ Other (please describe):_____

BLOOD VESSELS

□ Deep Vain Thrombosis □ Arteriosclerosis of leg vessels □ Artery bypass surgery
□ Calf pain with walking □ Enlargement of calf or thigh □ Leg or calf pain at rest
□ Cold legs □ Other:_____

GENERAL

□ Chronic Fatigue Syndrome □ Weakness □ Fatigue □ Insomnia □ Weight loss or gain
□ Diabetes □ Other:_____

RHEUMATOLOGIC

□ Rheumatoid Arthritis □ Fibromyalgia □ Lupus □ Scleroderma aching
□ Ankylosing Spondylitis □ Psoriatic Arthritis □ Reiters Syndrome □ Muscle
□ Joint swelling or deformity □ Other:_____

NEUROLOGIC

□ Multiple Sclerosis □ Seizure □ ALS □ Guillain-Barre Syndrome □ Disc Bulge
Left/right leg weakness: □ Pain □ Tingling □ Loss of sensation
Left/right arm weakness: □ Pain □ Tingling □ Loss of sensation
□ Other:_____

SPINE/ORTHOPEDIC/BONES

□ Fracture □ Dislocation □ Neck/back problems □ Motor vehicle injury □ Other:_____
_____

CANCER/BLOOD

□ Anemia □ Bleeding disorder □ List any cancer and dates:_____

Signature: _____

CONDITIONS OF TREATMENT

PATIENT RESPONSIBILTY: As a patient receiving medical care, I am aware of my insurance coverage limitations. Many insurance companies require pre-authorization for physical therapy treatments. It is my responsibility to determine insurance benefits and Orland Physical Therapy will assist me in obtaining the necessary pre-authorizations when needed as a courtesy. Failure to obtain necessary pre-authorization may result in a reduction or rejection of benefits by the insurance company.

ASSIGNMENT OF INSURANCE BENEFITS: I authorize my insurance company to pay Orland Physical Therapy & Sports Medicine, directly. I understand that I am responsible for charges not covered by my insurance company including late penalty charges. I agree that a photocopy of this authorization is as effective and valid as the original. I agree to provide all effective and applicable insurance information to be billed relating to my physical therapy treatment including but not limited to: WORKERS COMPENSATION, PERSONAL HEALTH INSURANCE, MEDICAL, AUTO INSURANCE CLAIMS, MEDICARE, ATTORNEY NAME AND CASE NUMBER.

CONFIDENTIALITY: Confidential information expressly identifies the medical nature of the services rendered to a patient, and includes all information and records obtained in the course of treatment. It includes information from history and physical examination.

MEDICARE AUTHORIZATION; PATIENTS CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information of the patient named below to release such information to the Social Security Administration, its intermediaries, or carriers, effective from this date to indefinite.

PRIMARY INSURANCE: We will be happy to bill your insurance for you once you provide us with the appropriate billing information. Your insurance will make payments directly to Orland Physical Therapy & Sports Medicine. You will be responsible for any deductible, co-pay or other patient balances.

SECONDARY/SUPPLEMENTAL INSURANCE: We bill the majority of secondary/supplemental insurance companies. Please check with the receptionist or billing manager if you have concerns about your secondary/supplemental insurance.

ATTORNEY INFORMATION/AUTHORIZATION: I agree to provide information regarding any attorney I have retained in relation to the accident/injury/other reason I'm seeking treatment at Orland Physical Therapy & Sports Medicine. I will appraise this office of all information regarding my case, attorney, and settlement. I agree to never rescind this document and that a rescission will not be honored by my attorney. I understand that I am directly and fully responsible for timely payments to Orland Physical Therapy & Sports Medicine, regardless of whether or not my settlement, judgment, verdict, insurance, or appeal covers the services charged from receiving physical therapy. I hereby authorize my attorney (name below patients signature) to pay directly to Orland Physical Therapy & Sports Medicine for all medical bills submitted by them for services rendered me.

I have read, understand, and agree to the conditions as stated above:

ACKNOWLEDGEMENT OF PRIVACY NOTICE RECEIPT:

I have been offered a copy of the Notice of Privacy Practices for M&C FOSTER INC. with an effective date of: 06-01-2003

PATIENT SIGNATURE DATE

SIGNATURE OF RESPONSIBLE PARTY IF DIFFERENT DATE

Attorney Name, address, City, State, Phone Number, Case Number

Financial Policy

Orland Physical Therapy & Sports Medicine
1351 Cortina Drive, Suite 110
Orland, CA 95963
Ph: (530) 865-8457
Fax: (530) 865-8462

This is an agreement between Orland Physical Therapy & Sports Medicine, as creditor, and the Patient/Debtor named on this form. In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Orland Physical Therapy & Sports Medicine.

It is our policy to discuss our fees and financial arrangements openly and honestly with you. Regardless of whether you have insurance coverage or not, you are responsible for the full financial cost of physical therapy treatment. By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Payment options if you have no insurance:
1. You can choose to pay by cash, check, or credit card on the day that treatment is rendered.
2. On extensive treatment, you may prefer to secure a bank, credit union, or other third-party financing for the entire amount and make payments to the lending institution.
3. We recommend special financing through Care Credit.

Payment options if you have insurance:
1. You can choose to pay your deductible and any out-of-pocket portions/co-pays at the time services are rendered by cash, check, or credit card, OR
2. You choose to pay all of your treatment by cash, check, or credit card. We will request your insurance carrier send their payment directly to you.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

The Financial Policy continues on the back side of this page.

Patient's name: _____

Responsible party
(if not the patient): _____

Signature: _____ Date: _____

Co-Signature: _____ Date: _____

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what

your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Finance Charge: A finance charge may be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of one percent (1%) per month or an **ANNUAL PERCENTAGE RATE** of twelve (12%) percent. The finance charge on your account is computed by applying the periodic rate (1%) to the overdue balance of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. The minimum Finance Charge is $.50.

Credit History: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Required payments: Any co-payments required by an insurance company must be paid at the time of service. This is an insurance requirement.

Returned checks: There is a fee (currently $25) for any checks returned by the bank.

Missed appointment fee: The second time a patients does not show up on time for an appointment, or cancels with less than 24 hours notice, a $20 fee will be charged. This fee must be paid before a new appointment is scheduled.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Glenn County, California.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Transferring of Records: You will need to request in writing, and pay a $15 copying fee if you want to have copies of your records sent to another organization, attorney or for yourself. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Workers Compensation: We require written approval/authorization by your employer and/or workers' compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.