

Orange County Doctors of Physical Therapy Inc.

12558 Valley View Street

Garden Grove, Ca 92845

Tel: (714) 901-7800 Fax: (714) 901-2300

INFORMATION FOR CASE HISTORY FILE

Patient's Name _____
Last First M.I.

Home Address _____
Street City State Zip Code

Date of Birth ____/____/19____ Home Phone () _____ Cell Phone () _____

Drivers License # _____ State of Issue _____ Social Security # _____ - _____ - _____

E-mail Address: _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY

Nearest Relative not living with you

Name _____ Phone Number () _____ Relationship _____

EMPLOYMENT INFORMATION

Employer _____ Work Number () _____ Occupation _____

Employer Address _____
Street City State Zip Code

School Info: _____
Name Street City State Zip Code

INSURANCE INFORMATION

Primary Insurance:

Name of Insured _____ Date of Injury _____

Social Security Number _____ - _____ - _____ Date of Birth ____/____/____

Name of Insurance Company _____ Telephone Number (____) _____

Insurance Address _____ City _____ State _____ Zip Code _____

I.D. Number _____ Group Number _____

Secondary Insurance: Yes _____ No _____ Name of Insurance: _____

I UNDERSTAND/AGREE THAT (REGARDLESS OF MY INSURANCE STATUS), I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. I HAVE READ ALL THE ABOVE INFORMATION ON THIS SHEET AND HAVE COMPLETED THE ABOVE ANSWERS. I CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDE. I WILL NOTIFY YOU OF ANY CHANGES IN MY STATUS OR THE ABOVE INFORMATION.

Signature _____ Date: ____/____/20____

Parent (If Minor) _____ Date: ____/____/20____

ORANGE COUNTY DOCTORS OF PHYSICAL THERAPY INC.

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment. All patients must complete our Information / Insurance Form before seeing the therapist.

Co-Pays are due at time of service – As you arrive for each appointment please register and pay co-pay at front desk. We accept Cash and Checks.

Regarding Insurance –The balance of your account for treatment rendered is your responsibility whether reimbursement from other sources such as insurance coverage’s workers compensation, motor vehicle insurance, or litigation may exist. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. Regarding Insurance Plans where we are a participating provider, you are responsible for co-pays, deductibles, and any non-covered services or equipment. In the event your insurance coverage changes to a plan where we are not participating providers, refer to above paragraph.

Changes in Your Insurance Coverage – It is that patient’s responsibility to inform this office of any and all changes of insurance coverage during the course of treatment received. Failure to do so may result in denial of coverage by your insurance company.

Usual and Customary Rates – Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company’s arbitrary determination of usual and customary rates.

Referral on File – AS PER YOUR COVERAGE, IT IS THE PATIENT’S RESPONSIBILITY TO OBTAIN A “REFERRAL ON FILE”. No referral on file may result in denial of insurance coverage for some or all of your treatment received. Please contact your insurance carrier immediately and review your insurance contract requirements for your plan. It is the patient’s responsibility to know, understand, and correctly follow their individual plan requirements. Orange County Doctors of Physical Therapy does not accept responsibility for any insurance carrier errors or misinformation supplied to either patient or Orange County Doctors of Physical Therapy.

Authorization Received – Authorization to treat received from your insurance carrier, does not guarantee payment for services rendered. Any portion of your treatment rendered that is established by your insurance plan, as “not covered service” is your payment responsibility.

Minor Patients – The parents (or guardians of the minor) are responsible for full payment of the minor child’s’ account.

Letters of Protection - Regardless of letter of protection all patients are responsible for payment of account balance in full.

Fee for NSF Checks- There is a \$25.00 Charge for Non-Sufficient Funds Checks received as payment from patients. Interest Charge Accrual- Interest automatically is accrued to accounts for unpaid charges over 90 days past due at 1.5%.

Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy.

PATIENT/RESPONSIBLE PARTY **SIGNATURE**: _____ **DATE**: _____

PATIENT RELEASE OF INFORMATION AND PAYMENT AUTHORIZATION

I authorize payment of medical benefits to the supplier, Orange County Doctors of Physical Therapy, for services rendered. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefit either to myself or to the party who accepts assignment below. (Reference HCFA Health Insurance Claim form Box 12)

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AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

I hereby authorize: _____
Physician/Healthcare Facility

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatments, diagnosis or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax or other electronic methods.

To: _____
Name

Address

City State Zip Code

The medical information/records will be used for the following purpose:

The Authorization is:

- Unlimited (all records)
 Limited to the following medical information: _____

Restrictions

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from our office or unless such disclosure is specifically required or permitted by law.

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

Signature of patient or legal/personal representative

Relationship if other than patient

Patient's Name (PRINT)

Date