Los Gatos Orthopedic Sports Therapy

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____
Social Security #: _____ Marital Status: S / M / Other Sex: M / F
Date of Birth: _____ Phone Number: _____ Cell #: _____
Email: _____Would you like confirmation by? Email / Phone/Text
Address: _____City: _____State: _____Zip: _____
Where is your injury? _____ Date Injured: _____
How did you hear about us? _____
Accident related injury: Yes / No Employment related injury: Yes / No
Occupation: _____
Employer: _____Work Phone #: _____
Address: _____ City: _____State: _____ Zip: _____

Recent regulations require us to present you with the Notice of Privacy Practices. I have been presented with this notice. _____ Date: _____
(Signature)

LOS GATOS ORTHOPEDIC SPORTS THERAPY, Inc.

FINANCIAL POLICY AND PATIENT CONTRACT

Dear Patient:

Thank you for choosing Los Gatos Orthopedic Sports Therapy Inc. for your rehabilitation services. We realize that in today's health care environment, you have choices for your care and services. Please take the time to read and sign the following Financial Policy and Contract between Los Gatos Orthopedic Sports Therapy, Inc. and yourself. Please do not hesitate to contact our office staff for further explanation or information.

Los Gatos Orthopedic Sports Therapy Inc. will bill your health insurance company for the physical therapy services rendered to you. Our office staff will provide you your policy insurance benefits by the second appointment, notify you if we require further information or assistance in filing your claim and assist you in obtaining the maximum benefits provided by your health insurance plan. It is important that you read your individual health insurance policy handbook to familiarize you with the benefits provided to you, as well as limitations or conditions thereof. If you need assistance understanding your policy benefits, limitations or conditions, please ask our Office Manager for assistance.

Please note: If your injury is related to an injury that occurred at work (Workers Compensation) or in a motor vehicle accident, it will be necessary for you to provide our office with the following:

- Insurance Carrier's name
- Claim number
- Claim adjuster's name, address and phone number

As a courtesy to our patients, our office staff will file the necessary benefits claim's form. However, all charges for services rendered are your responsibility from the date of service.

1. The health insurance company, workers compensation insurance company or motor vehicle insurance company is your insurance company and provides benefits to you, as a result of contractual relationship between them, yourself and in some cases your employer. This is a document between Los Gatos Orthopedic Sports Therapy Inc. and yourself.
2. Your insurance policy may provide payment of *LESS* than our customary fee and not all services provided to patients are covered benefits under the individual insurance plans.
3. Los Gatos Orthopedic Sports Therapy Inc. should receive payment from your insurance company within 45 days of the services being provided to you. After that time, you will be responsible for the payment of any or all outstanding balances.
4. If your insurance company has informed us that they will not pay for services provided to you in full, our office staff will provide you with a monthly statement indicating that portion of your bill for which you are immediately responsible. Payments can be made by cash, check or credit card.
5. If you are aware or if your insurance company informs us that your insurance policy provides for a co-payment at the time services are rendered, we will expect you to make such co-payments at the time of your appointment.
6. If you are not insured for the services provided, please make payment arrangements with our office staff prior to beginning physical therapy.
7. All patients are required by signing this document agree to pay Los Gatos Orthopedic Sports Therapy Inc. the balance (if any) of their account after crediting the payments made by their insurance carrier.

Cancellations: Please notify us as soon as possible of the necessity to reschedule an appointment for physical therapy. **A minimum of twenty four (24) hours' notice is appreciated**. If it is necessary for you to cancel an appointment on the same day that the appointment is scheduled; and the time scheduled for your appointment cannot otherwise be filled, a **$50.00 charge will apply**. Such a charge will *not* be covered by any insurance carrier.

Research: Los Gatos Orthopedic Sports Therapy Inc. is actively involved in multiple research projects. The treatment intervention used during physical therapy visits and outcome data collected at discharge may be used for current or future research. Your personal information will not be used or released publicly. Signing below gives Los Gatos Orthopedic Sports Therapy Inc. permission to use data collected during your physical therapy sessions in current/future research projects.

Failure to show up for appointment (No Shows): If you fail to show up for an appointment without notification a **$50.00** charge will apply. This charge is not covered by any insurance carrier. This charge will be strongly enforced with Workers Compensation patients because the State of California is covering the medical services provided to you.

Important Billing Notice: When you send us a check as payment, you authorize Los Gatos Orthopedic Sports Therapy to clear your check electronically. If you usually get your checks back with your statement, you will not receive this check back.

Attorney's Fees and Costs: In the event that it is necessary for Los Gatos Orthopedic Sports Therapy Inc. to refer your unpaid account to an attorney for legal action, including the filing of a claim for monetary damages and should Los Gatos Orthopedic Sports Therapy Inc. be successful in obtaining a judgment against you, then you agree to pay

in addition to the balance due and all applicable finance charges, such reasonable attorney's fees and costs as the court may assess against you.

I understand and agree regardless of my insurance status, that I am ultimately responsible for the payment of services provided to me by Los Gatos Orthopedic Sports Therapy Inc. Initials:_____

I certify that I have read this document in its entirety and agree to the terms and conditions contained herein. A copy of this document will be accessible to you at any time. Initials:_____

PLEASE PRINT FULL NAME: _____
PLEASE PRINT PATIENT'S FULL NAME (if different):_____

Signature:_____Date:_____

Elite Arm Care Program

- ○ 1 session = $50
- ○ 4 Pre-Paid Sessions = $40/visit = $160

Signature:_____ Date:_____