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
Account Type: Private / Worker's Compensation / Auto
Occupation: _____
Employer: _____Work Phone #: _____
Address: _____ City: _____State: _____ Zip: _____

Payor Name: Who is responsible for bill: Self / Spouse / Parent / Employer / Attorney
If different from above, Name: _____ Phone#: _____
Address: _____ City: _____State: _____Zip: _____

Primary Insurance: _____ Adjuster: _____
Group #: _____ Insured ID # _____/ SSN#: _____
***If different from yourself,* Insured Name**: _____
Your relation to insured: Spouse / Child / Other
Insured Birthdate: _____ Insured sex: Male / Female
Insured Address: _____ City: _____State: _____Zip: _____
Insured phone number: _____ Insured employer: _____

Secondary Insurance: _____ Adjuster: _____
Group #: _____ Insured ID #_____ / SSN#: _____
If different from yourself, Insured Name: _____
Your relation to insured: Spouse / Child / Other
Insured Birthdate: _____ Insured sex: Male / Female
Insured Address: _____ City: _____State: _____ Zip: _____
Insured phone number: _____ Insured employer: _____

DOCTOR INFORMATION
Referral Doctor: _____ Date returning to referring doctor: _____
Primary Doctor: _____

Have you received physical, occupational or speech therapy at any other facility during the previous
12 months. _____yes ____no. Name of facility_____
Address/phone _____

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
PROactive Orthopedic & Sports Rehabilitation:
"One Team, One Goal"
16615 Lark Avenue Suite 101 ●Los Gatos, CA 95032-2028
PHONE: 408-358-1460 FAX: 408-358-1459
www.lgost.com

Name: _____

Date: _____

PAIN INTENSITY SCALE

PAIN INTENSITY: In the past 24 hours, mark a point on the line below indicating your pain.

No Pain {_____} Worst pain possible

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 authorize Los Gatos Orthopedic Sports Therapy Inc. to file a complaint on my behalf to the California State Insurance Commission in such a case where my insurance is not following compliance guidelines. Initials: _____

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:_____

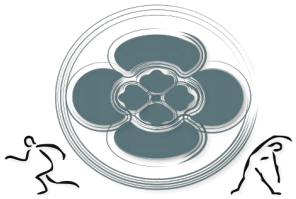
PLEASE PRINT FULL NAME: _____
PLEASE PRINT PATIENT'S FULL NAME (if different):_____

Signature:_____Date:_____

ASSIGNMENT AND RELEASE OF INSURANCE BENEFITS
I hereby authorize my insurance benefits of any kind to be paid directly to Los Gatos Orthopedic Sports Therapy Inc. I further authorize Los Gatos Orthopedic Sports Therapy Inc. to release my medical records or information to any insurance company as necessary or required to process my insurance claims.

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

Signature:_____



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AUTHORIZATION FOR CREDIT CARD PAYMENT

I Authorize Los Gatos Orthopedic Sports Therapy, Inc. (LGOST) to automatically charge my credit card (Visa, MasterCard) for items listed on the monthly statements for:

_____
Name of Patient

The Payment Plan option I prefer is marked below:

□ **Daily Plan:** I authorize LGOST to charge me the day of each visit I attend physical therapy for services rendered relating to copayments and/or patient portions due.

Credit Card: Visa or MasterCard

Credit Card #: _____

Expiration Date (MM/YY): _____

First/Last Name on Card: _____

3 Digit Security Code on Back: _____

Amount LGOST is to deduct: _____

Receipts: Printed or E-Mailed

If you agree with the said information above, please sign and date below:

_____ _____
Patient Signature Date

16615 Lark Ave. Suite 101 Los Gatos, CA 95032

(408) 358-1460 Fax (408) 358-1459

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AUTHORIZATION TO RELEASE RECORDS

You are hereby Authorized and requested to furnish to :

_____

_____

or his representative, all my medical records and reports and summaries thereof and bills and statements and all other information pertaining to me to permit them to examine all originals and to make copies thereof.

_____ _____

DATE NAME

_____

SIGNATURE

Los Gatos Orthopedic Sports Therapy, Inc.

NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to this information.

Please review it carefully.
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. As required by HIPAA, Orthopedic Sports Therapy has prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use or disclose personal health information when we are required to do so by law. We use and disclose health information about you for treatment, payment and healthcare operations.

Treatment means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include discussing your physical examination with your physician.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Healthcare Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functional, cost management analysis and customer service. An example would be evaluating provider performance for improved quality of care. We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. Please advise us in writing if there are certain restrictions to how you want to be contacted and how messages should be left. An example would be calling or emailing you to confirm an appointment.
Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer: Kris Nakaji at our office phone number, fax number or address.

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The right to request restriction on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close person friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. The right to reasonable requests to receive confidential communication of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of October 1, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office.

In conclusion, please understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) you have certain rights to privacy regarding your protected health information. Understand that this information can and will be used to:

- Conduct, plan and direct your treatment and follow-up among the multiple healthcare providers who may be involved in your treatment directly or indirectly.
- Obtain payment from your insurance company and any third-party payer.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

Please understand that this organization has the right to change its Notice of Privacy Practices from time to time and that you may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

Please understand that you may request in writing restrictions on how your private information is used or disclosed to carry out treatment, payment or health care operations. Also understand Orthopedic Sports Therapy is not required to agree to your personal restrictions, but if Orthopedic Sports Therapy does agree than we are bound to abide by such restrictions.

Please understand that you may revoke this consent in writing at any time, except to the extent that Orthopedic Sports Therapy has taken action relying on this consent.