COAST
Physical Therapy Specialists

WELCOME TO COAST
Physical Therapy Specialists

Dear Patient:

WELCOME to COAST Physical Therapy Specialists. For many of you, this will be your first contact with the Physical Therapy profession. In brief, our therapists are educated and trained professionals who treat physical dysfunction's and provide orthopedic rehabilitation. Our staff is committed to work with you to achieve your goals and to help you return to a fully productive and independent lifestyle.

Your physician has recommended and referred you to physical therapy for a specific problem. Based upon this referral, our therapists will perform an evaluation, develop a treatment plan and manage your injury or disease. We will continually re-evaluate your progress and regularly report your progress to your physician. In order for the Therapist to report your progress to the Physician, it is imperative to attend the program as outlined. Missing sessions could adversely affect the rehabilitation process, lessening the positive effects of the program and possibly prolong your return to normal activities.

Physical Therapy is for your benefit. Therefore, it is important that you take an active role in the rehabilitation process so that you will obtain the maximum benefit from your program. During your program, you may be asked to perform certain activities at home. It is very important that you carefully follow the instructions given and perform the activities, as they will assure you of a quicker recovery. It is also important that you feel free to communicate both positive and/or adverse reactions to activities done either in the clinic or those you are doing at home. This information will assist the therapist in modifying your program so that the maximum benefit will occur. You will find that we are quite open-minded about your individual problem and very much will listen to what you have to say and feel. If you find it necessary to cancel an appointment, please be kind enough to give us a 24-hour notice and attempt to talk to your therapist so that he/she can determine whether any modification of your program should take place.

We truly look forward to helping you achieve your goals and hope that you will enjoy an improved quality of life!

Kindest Regards,

THE ENTIRE STAFF
COAST PHYSICAL THERAPY SPECIALISTS

_____ _____

Patient Signature **Date**

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NEW PATIENT INFORMATION SHEET

Patient Name; (Last)_____(First)_____(MI)_____

Appointment Date:____/_____/_____ Appointment Time:_____ Account #:_____

PERSONAL INFORMATION

Social Security #: _____-_____-_____ Birth Date: ____/_____/_____ Sex: M or F

Home Address: _____ Home Phone: (_____)_____-_____

City: _____State:_____Zip:_____ Work Phone: (_____)_____-_____

Employer:_____ Cell Phone: (_____)_____-_____

Employer Address:_____City:_____State:_____Zip:_____

Occupation:_____ Marital Status:_____

Emergency Contact Name:_____ Email Address:_____

Relationship to Patient:_____ Contact Phone: (_____)_____-_____

INSURANCE INFORMATION

Insurance Name:_____ ID/Policy #:_____

Group Name:_____Group #:_____Claim #:_____

Claim Phone #: (_____)_____-_____ Claim FAX #: (_____)_____-_____

Plan associated with IPA: Y or N IPA Name:_____

Secondary Insurance Name:_____

Secondary Ins. Policy #: _____ Verification Phone #: (_____)_____-_____

PAYOR INFORMATION

Insured Name:_____ Relationship to Patient:_____

Insured SSN:_____-_____-_____ Home Phone: (_____)_____-_____

Home Address:_____ Work Phone: (_____)_____-_____

City:_____State:_____Zip:_____ Birth Date: ____/_____/_____ Sex: M or F

Employer:_____

Employer Address:_____City:_____State:_____Zip:_____

INJURY INFORMATION

Have you had previous surgery for this injury? Yes or No Date of Injury/accident: _____/_____/_____

Injury Type: Work / Auto / Other (accident/injury due to other than Auto or work) or None (not an accident)

Injury Details (Body Part):_____

_____

(If accident – include where and how it occurred / if non-accident, include reason for visit)

State where accident occurred:_____

REFERRING PHYSICIAN INFORMATION

Referring Physician Name:_____ Phone#:(_____)_____-_____

Physician Address:_____ Fax #: (_____)_____-_____

City:_____State:_____Zip:_____ NPI:_____

Prescription Date:_____/_____/_____# of Visits ordered:_____Special Instructions:_____

_____

FOR OFFICE USE ONLY

Therapist: _____ Therapist's Code: _____

_____ _____

Patient Signature *(certifying that all personal information above is correct)* ***Date***

COAST
PHYSICAL THERAPY SPECIALISTS

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for COAST Physical Therapy Specialists to furnish medical care and treatment considered necessary and proper in diagnosing or treating (Patient) _____'s physical and/or mental condition.

Patient/Responsible Party:_____ **Date**:_____

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

PATIENT'S NAME: _____

POLICY HOLDER: _____ INSURANCE COMPANY: _____

- I hereby instruct and direct my Insurance Company to issue checks made out and mailed directly to :COAST PHYSICAL THERAPY SPECIALISTS (1701 Solar Drive, Ste 155, Oxnard, CA 93030) for the professional and/or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY**. A photocopy of this assignment shall be considered as effective and valid as the original.
- I hereby authorize said assignee to release all information necessary to my Insurance Company, Adjustor, Doctor's office, or Attorney involved in my case.
- **MY CONDITION IS NOT A WORKER'S COMPENSATION CASE OR PART OF A LIEN** (Unless otherwise noted)_____ (Patient's Initials)

I authorize COAST Physical Therapy Specialists to furnish information to my insurance carrier(s) concerning my treatment, and I hereby assign all payment for services rendered. I agree to pay any outstanding balances after my insurance carrier has paid its portion of the bill.

Patient/Responsible Party: _____ Date: _____

FINANCIAL POLICY STATEMENT

We will bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that payment of your estimated share be made on the date of service. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made to COAST, you will be responsible for the full amount of money refunded to your insurance company. In the event that your insurance company establishes an internal *usual and customary fee schedule*, you will be responsible for the difference remaining**. If your insurance makes any payments directly to you for services rendered by us, you recognize an obligation to promptly submit the payment to COAST Physical Therapy Specialists**. I understand and agree that if I fail to make the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Patient/Responsible Party: _____ Date: _____

COAST
PHYSICAL THERAPY SPECIALISTS

NOTIFICATION OF PATIENT RESPONSIBILITY FOR CO-PAYMENTS/CO-PERCENTAGES AND DEDUCTIBLES

Your company requires Coast Physical Therapy Specialists to collect your co-payments or co-percentages and any un-met deductible amounts from you at the time of service. If we do not collect these amounts, we could be in direct violation of our contract with your insurance company and could be at risk being denied reimbursement for your treatment.

COAST has verified your physical therapy benefits based on the information given by you. **Your insurance company writes the disclaimer that this is a verification of benefits and not a guarantee of payment**. Based on the information your insurance company provided us with, your benefits are as follows:

Co-Payment: _____ **/visit** **Co-Percentage:** _____**/visit** **Estimated amount:** _____**/visit**

Deductible: _____ **Amount not met:** _____ **Maximum visits allowed:** _____**/year**

PLEASE NOTE: *If you have already paid your deductible to another provider but our claims are received first by the insurance company, the deductible will be applied to our claim and you will owe the balance to COAST. You will then need to obtain a refund from the provider that originally collected your deductible from you.*

ESTIMATED coverage information is provided as a courtesy to our patients, but is not intended to release them from total responsibility for their account balance. The estimate is based on a negotiated contract and any remaining balance due will be billed to you after additional information is received from your insurance company. Reimbursement of services are based on your specific insurance plan, and any discrepancies are strictly between you and your insurance carrier. Please do not hesitate to contact us regarding your billing concerns.

I HAVE READ THIS FORM ENTIRELY AND UNDERSTAND MY FINANCIAL RESPONSIBILTY FOR THE PAYMENT OF MY ACCOUNT. I AGREE TO REMIT PAYMENT AS AGREED ON THE DATE OF SERVICE.

Patient/Responsible Party: _____ Date: _____

NO SHOW / APPOINTMENT CANCELLATION POLICY

- Please provide our office with at least a 24-hour notice to change or cancel an appointment. We have an answering machine that you are more than welcome to use for after hours and on the weekends.
- We reserve your appointment time just for you. We do not double-book our patients so that we may provide optimum treatment outcomes for all our patients. 24-hours notice allows us to place another patient in your cancelled appointment period to receive needed treatment.
- **If 3 or more appointments are missed consecutively at any time during a patient's rehabilitation, any further appointments you may have already scheduled may be taken off the schedule**. The patient will then be required to schedule their appoint each day they plan on attending therapy, provided an opening is available.
- **A charge will be applied for "No-Show" or "Non 24-Hour" cancellations**. Please avoid the inconvenience and give us the courtesy of a phone call at least 24-hours in advance.

Patient/Responsible Party: _____ Date: _____

Medical History

Existing or Relevant Previous Conditions

Allergies	◯ Yes ◯ No	Dizzy Spells	◯ Yes ◯ No	MRSA	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Emphysema/Bronchitis	◯ Yes ◯ No	Multiple Sclerosis	◯ Yes ◯ No
Anxiety	◯ Yes ◯ No	Fibromyalgia	◯ Yes ◯ No	Muscular Disease	◯ Yes ◯ No
Arthritis	◯ Yes ◯ No	Fractures	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Gallbladder Problems	◯ Yes ◯ No	Parkinsons	◯ Yes ◯ No
Autoimmune Disorder	◯ Yes ◯ No	Headaches	◯ Yes ◯ No	Rheumatoid Arthritis	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Hearing Impairment	◯ Yes ◯ No	Seizures	◯ Yes ◯ No
Cardiac Conditions	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Smoking	◯ Yes ◯ No
Cardiac Pacemaker	◯ Yes ◯ No	High/Low blood pressure	◯ Yes ◯ No	Speech Problems	◯ Yes ◯ No
Chemical Dependency	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Strokes	◯ Yes ◯ No
Circulation Problems	◯ Yes ◯ No	HIV/AIDS	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Currently Pregnant	◯ Yes ◯ No	Incontinence	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Depression	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Vision Problems	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Metal Implants	◯ Yes ◯ No		

Describe any other conditions

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions

Fall History

- ☐ Injury as a result of a fall in the past year?
- ☐ Two or more falls in the last year?

HEIGHT : _____

WEIGHT: _____

Surgical History

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Current Medications

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

☐ Currently not taking any medications