ORTHOPEDIC PHYSICAL THERAPY ASSOCIATES
10921 Wilshire Blvd SE 1208
Los Angeles, CA 90024
424.260.2974 • Fax 424.260.2980
orthopedicphysicaltherapy20@gmail.com

MEDICATIONS LIST

Patient's Name: _____ Patient's Height: _____

Patient's Date of Birth: _____ Patient's Weight: _____

Please list all the medications that you are currently taking. Make sure to put the correct name of the medication as well as the dosage and the amount of times medication is taken. Such as, how many times per day or week, etc.

Medication Name	Dosage	Frequency

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INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand Orthopedic Physical Therapy Associates' Notice of Information Practices. I understand that Orthopedic Physical Therapy Associates may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the equity of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Orthopedic Physical Therapy Associates will consider requests for restrictions on a case-by-case basis but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for the purposes as noted in Orthopedic Physical Therapy Associates' Notice of Information Practices. I understand that I retain the right to evoke this consent by notifying the practice in writing at any time.

_____
Patient Name

_____
Signature

_____
Date

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FINANCIAL POLICY

Dear Patient:

Thank you for choosing us as your health care provider the following is our *Financial Policy.* Our main concern is that you receive the proper and optimal treatments needed to restore your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask our billing department.

We ask that all patients read and sign our Financial Policy as well as complete our Patient Information Form prior to seeing the therapist.

Payment for services is due at the time services are rendered. We accept cash checks or credit card. We will be happy to help you process your insurance claim for our reimbursement as long as you provide us with proper insurance information.

In special instances, we may accept assignment of insurance benefits. However, you must understand that:

1. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company.

2. All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not **cover.**

3. Fees for these services, along with unpaid deductibles and co-payments, are due at the time of treatment.

4. If your insurance company does not pay your claim, we ask that you contact your insurance carrier to help speed things up.

5. If you are injured and you are a member of a Preferred Provider Group (such as a PPO or a HMO), we are entitled to 100% of the normal and customary physical therapy charges upon collection of damages by way of settlement.

6. Returned checks and balances older than 45 days may be subject to additional collection fees and interest charges of 1 to 1-1/2% per month.

Please note that unless cancelled at least 24 hours in advance, you may be charged for missed appointments at the rate of a normal office visit. Please call to reschedule.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

_____ _____

Signature Date

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PATIENT INFORMATION FORM

Referring physician_____

Name: _____ Age: _____ Date of Birth: _____

Address: _____
Street City & State Zip Code

Home #: _____ Mobile #: _____ Bus. #: _____

Email Address: _____

Business Address: _____
Street City & State Zip Code

Driver's License # & State: _____ Social Security: _____

Spouse's Name: _____ Employer: _____

Business Address: _____ Bus. #: _____

Closest relative not living in same household: _____ Ph. #: _____

BILLING AND INSURANCE INFORMATION

Please Check One: ☐Workers' Comp. ☐Personal Injury ☐Insurance ☐Cash

Name of Insurance Carrier: _____ Date of Injury: _____

Address: _____
Street City & State Zip Code

Adjuster's Name: _____ Phone Number: _____

Subscriber #: _____ Group #: _____ WCAB Case #: _____

Insured Party: ☐Self ☐Spouse ☐Father ☐Mother ☐Other (name & relationship) _____

Address (of other): _____ Phone Number: _____

Do you have an attorney for this injury (please check one)? ☐Yes ☐No Attorney Name: _____

Attorney's Name: _____ Phone Number: _____

AUTHORIZATION TO PAY PHYSICAL THERAPIST AND FINANCIAL AGREEMENT

I hereby authorize the physical therapist in charge of my case to furnish my insurance company with information concerning my hospital and medical or surgical treatment.

I hereby authorize and instruct my insurance company to pay by check made out to and mailed directly to: *Joel Scherr, R.P.T. 8635 West Third Street, Suite 465W, Los Angeles, California 90048* the medical and surgical benefits allowable, and otherwise payable to me under current insurance policy, as payment toward the total charges for Professional Services Rendered. This payment will not exceed my indebtedness to above mentioned assignee, and I agree to pay, in a current manner, any balance of said Professional Services charges over and above this insurance payment. If legal action becomes necessary to enforce payment, I agree to pay a reasonable attorney fee.

_____ _____
Name Date

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PATIENT HISTORY FORM

Name: _____ Gender _____ Date of Birth: _____

Do you now have, or have ever had, any of the following (please check one)? ☐Yes ☐No

Diabetes	☐Yes	☐No	Allergies	☐Yes	☐No
High Blood Pressure	☐Yes	☐No	Previous Surgery	☐Yes	☐No
Pacemaker	☐Yes	☐No	Seizures	☐Yes	☐No
Chronic Headaches	☐Yes	☐No	Metal Implants	☐Yes	☐No
Liver / Kidney Conditions	☐Yes	☐No	Dizziness	☐Yes	☐No
Nervous Disorders	☐Yes	☐No	Cancer	☐Yes	☐No
Bone Disease / Fractures	☐Yes	☐No	Osteoporosis	☐Yes	☐No
Bowel / Bladder Conditions	☐Yes	☐No	Anemia	☐Yes	☐No
Breathing Conditions	☐Yes	☐No	Depression	☐Yes	☐No
Circulatory Disease	☐Yes	☐No	Glaucoma	☐Yes	☐No
Heart Conditions	☐Yes	☐No	Corneal Implants	☐Yes	☐No
Stroke / CVA	☐Yes	☐No	Smoker	☐Yes	☐No
Thyroid Conditions	☐Yes	☐No	Currently?	☐Yes	☐No
Hernia	☐Yes	☐No	Other Illness	☐Yes	☐No

If YES to any of the above, please explain, give dates and appropriate details:

_____

_____

_____

_____

Are you currently pregnant (please check one)? ☐Yes ☐No

List any medications you are currently taking:

_____

_____

Have you ever had physical therapy treatments for this current problem before (please check one)? ☐Yes ☐No

If YES, indicate where, when and was the treatment effective:

_____

_____

_____ _____

Signature Date

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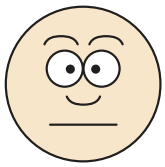
WONG-BAKER FACES PAIN SCALE

0 - Very happy, no hurt

1 - Hurts just a little bit



2 - Hurts a little more

3 - Hurts even more

4 - Hurts a whole lot

5 - Hurts as much as you can imagine
(Don't have to be crying to feel this much pain)

Next to each face, using the words to describe the pain intensity, ask patient to choose the face that describes own pain and record the appropriate number.

1. Very happy, no hurt
2. Hurts just a little bit
3. Hurts a little more
4. Hurts even more
5. Hurts a whole lot more
6. Hurts as much as you can imagine (Don't have to be crying to feel this much pain)