Orthopedic Physical Therapy and Wellness, Inc.
20 Sycamore St., San Francisco, Ca 94110 Ph. (415) 480-8011
333 Valencia St., San Francisco, Ca 94103 Fx. (415) 255-8211
www.OPTWINC.com OPTWINC@gmail.com

AUTHORIZATION FOR THE RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS, FINANCIAL RESPONSIBILITY AND NOTICE OF LIEN

PATIENT INFORMATION

Therapist: *John Soriano, PT*	Discipline: *Physical Therapy*		Admission Date: / /
Patient's Last Name, First Name	Phone Number (Home or Mobile):		Email Address:
Social Security Number:	Phone Number (Work):		Preferred method of contact. Check all that apply. (Call ☐ Text ☐ Email ☐)
Date Of Birth:	Age:	Marital Status:	How did you hear about OPTWINC?
Address: City: State: Zip Code:			Are you right or left handed? **Right** What is your ethnicity?
Legal Guardian: (if applicable) & Relationship to Patient: Phone Number:			Do you have a membership to a gym? If so, which gym?
Emergency Contact: Relationship to Patient Phone Number (Home or Mobile) Phone Number (Work)			
Referring Physician's Name:	Physician's NPI:		Physician's Email Address:
Physician's Address:	Physician's Phone Number:		Physician's Fax Number: ( ) --
For office use only			
Diagnosis:	ICD Code:		Date Of Onset:
Diagnosis:	ICD Code:		Date Of Onset:

INSURANCE INFORMATION

Primary Insurance:	Name of Insured:	ID Number:
Insurance Plan:	Program Name:	Group Number:
Billing Address: State: Zip Code:		Phone Number ( ) -- Fax Number: ( ) --
Secondary Insurance:	Name of Insured:	ID Number:
Insurance Plan:	Program Name:	Group Number:
Billing Address: State: Zip Code:		Phone Number ( ) -- Fax Number: ( ) --

I authorize the treatment for Physical, Occupational, and Speech Therapy services. I authorize the release of information for claim purposes and understand that payment for these services will be directed to the company providing rehabilitation services. I understand that in the event I do not have supplemental insurance or my supplemental insurance company denies payment, I will be responsible for the 20% of medical charges. I understand that I am fully responsible to directly and fully compensate or have my attorney directly compensate such sums from my settlement, judgment, verdict or claim to Orthopedic Physical Therapy & Wellness Inc. for physical therapy services rendered as a result of the injuries for which I have been treated and any other physical therapy office bills.

Patient Signature:	Date: / / 2014
Guardian Signature:	Date: / / 2014

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Medical Questionnaire

PATIENT'S NAME *LAST, FIRST, MI*	
ADDRESS *STREET* *APT #* *CITY* *STATE* *ZIP CODE*	
RESPONSIBLE PARTY *SELF, IF OVER 18* Self	**RELATIONSHIP**

Who is to be billed? ☐Private Insurance ☐Medicare ☐Workers-Comp ☐Out of Pocket/Cash
☐Health Savings Acct ☐Lien ☐Other: _____

Area(s) of Injury	**Date Injury Began**
1.	1.
2.	2.
3.	3.

Allergies:
Medications: _____
Food, mold, pollen, etc.: _____

Other Health Conditions: ☐Diabetes ☐HIV ☐Neuropathy ☐High Blood Pressure
☐Arthritis ☐Other: _____

Current Medications: _____
(If more space is needed, list medications on back)

Vitals: Blood Pressure: _____ / _____ Heart Rate: _____

Who referred you? How did you hear about us? _____

What medical professionals have you seen in the past two years?

	Physician	**Medical Condition(s)**	**Approx Date of Visit**
1.			____ / ____ / ____
			____ / ____ / ____
2.			____ / ____ / ____
			____ / ____ / ____
3.			____ / ____ / ____
			____ / ____ / ____
4.			____ / ____ / ____
			____ / ____ / ____

By signing below I agree to the following:

- The information I have provided on this form is complete and accurate to the best of my knowledge.
- I authorize payment directly to Orthopedic Physical Therapy and Wellness Inc. for physical therapy services rendered. I understand that I am financially responsible for charges not covered by third party payers/MEDICARE and Private Insurances.

Patient Signature: _____ **Date:** _____

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Physical Therapy Consent and Appointment Policy

By signing this consent, I am agreeing to the stipulations and requirements of the Physical Therapy Program. I, _____, agree to participate in the Physical Therapy Program for the previously agreed-upon fee.

Appointment Scheduling, Rescheduling and Cancelling

- To schedule an appointment call the office at **(415) 480-8011** or email at **OPTWINC@gmail.com**
- To reschedule or cancel an appointment, call the office at **(415) 480-8011** or email at **OPTWINC@gmail.com** 24 hours before the scheduled appointment. Do not call the gym or trainer.
- Calling to reschedule or cancel an appointment within 24 hours of the session will cause you to forfeit the appointment without a refund or replacement.
- Cancelling appointments two consecutive times, or not showing up to two consecutive appointments without rescheduling 24 hours in advance, will cause the cancelling of all future appointments. To schedule another appointment, it is necessary to come to the gym or office and sign for the two missed appointments and sign for the future appointment at least a day in advance.

I am aware that a different PTA (Physical Therapy Assistant) can be assigned to work with me at any time as deemed necessary by Orthopedic Physical Therapy and Wellness Inc. A PTA will provide me with my fitness goals and the components (food intake, cardio, respiratory, supplementation, resistance training and professional assistance) necessary for me to achieve my goals, which will be discussed during the first session. In addition to each 55-minute individualized session, my personal PTA will monitor my progress during the program and provide me with educational materials, adjustments to my components, and, if necessary, a revised fitness goal.

Finally, I agree to read and complete all forms required to continue sessions. I also agree to attend scheduled appointments and comply with the Physical Therapy Program designed to assist in the achievement of my goals. In signing, I am giving my consent to participate in the Physical Therapy Program designed for me by Orthopedic Physical Therapy and Wellness Inc.

Client Signature _____ Date _____

Printed Name _____

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HIPAA Notice of Privacy Practices

Health Insurance Portability and Accountability Act of 1996 (HIPAA) Patient Acknowledgement

I, _____, have fully read and understand the

HIPAA Notice of Privacy Practices provided to me by Orthopedic Physical Therapy and Wellness Inc.

- I also understand how my "protected health information" (PHI) may be disclose for treatment plans, payment purposes, and health care operations, in order to receive health care services at Orthopedic Physical Therapy and Wellness.
- I understand that my PHI may be used for research purposes and my PHI will be disclosed only with a proper-signed informed consent.
- I understand that under special situations as required by law, or for lawsuits and other legal disputes or national security, my PHI will be disclosed without my authorization.
- I also understand about my rights as a patient and the fact that I can use them at any time if necessary.
- I understand as well that my authorization is required before my PHI may be used or disclosed by Orthopedic Physical Therapy and Wellness Inc. for other purposes.

I acknowledge that I have fully read and understand the HIPAA Notice of Privacy Practices and its content. My therapist or physical therapy assistant explained and answered all the questions I had regarding this matter.

_____ _____

Patient Signature Date