TAG PHYSICAL THERAPY FINANCIAL POLICY

Thank you for choosing TAG Physical Therapy - we are committed to providing you with the best possible service and ask that you read and acknowledge the terms of our Financial Policy.

PAYMENT: All payments including copay, coinsurance and deductible are due on the date of service. We accept cash, checks, Visa, MasterCard, American Express and Discover credit cards. As a courtesy to our patients, we will contact your insurance provider to verify your physical therapy coverage. We cannot, however, guarantee the accuracy of the information we receive from your insurance provider.

COINSURANCE/DEDUCTIBLE: If you have a plan with coinsurance percentage or deductible which has not been met, we will estimate the coinsurance/deductible amounts based on what we have been lead to expect your insurance company will pay. Please note that any payment made on the date of service is considered a **DEPOSIT** toward your **ESTIMATED** patient balance. Because this is an estimate, there is always the possibility that you may be either responsible for an additional balance or due a refund. If a refund is due – it will be promptly provided. If it turns out that your insurance company payment is less than expected – you are responsible to promptly pay any additional balance due. An unpaid balance over 30 days past due may be referred to a collection agency.

***I have read and understand the above. Please initial here: _____**

INSURANCE: We encourage you to call your insurance company with any specific questions related to your policy's outpatient physical therapy benefits such as deductible, copayment, coinsurance, visit limitations i.e., sharing of outpatient benefits with acupuncture, chiropractic or occupational care, effective annual calendar renewal date, or any pre-authorization requirements.

TAG Physical Therapy cannot assume responsibility for incorrect information provided to us concerning your insurance policy. Our courtesy verification of eligibility and benefits does not guarantee that your insurance company will pay for all services provided. Your insurance policy is a contract between you and your insurance company. You are responsible for knowing your level of coverage and are ultimately responsible for the full payment of your bill.

CANCELLATION POLICY: Therapist time is reserved for your appointment – if you are unable to keep your appointment we kindly ask that you provide us with 24-hour advance notice of cancellation. If you fail to cancel a scheduled appointment 24 hours in advance, or "no-show" an appointment, we reserve the right to assess a $50.00 cancellation fee.

I have read and understand the above TAG Physical Therapy Financial Policy, agree to the terms, and understand that I am ultimately responsible for payment of the health care services provided.

_____ _____

Printed Patient Name Printed Name of Guarantor (if applicable)

_____

Signature of Patient (or Guarantor) Date

TAG PHYSICAL THERAPY
111 Penn Street
El Segundo, CA 90245
(310) 426-9570 Fax (310) 426-9572

Date: _____ Referring Doctor: _____

PLEASE PRINT CLEARLY Home Phone: _____

First Name: _____ Cell Phone: _____

Last Name: _____ Birth Date: _____

Address: _____ Social Security #: _____

City, St., Zip: _____ Sex: _____ Age: _____

Single _____ Married _____ Widowed _____ Separated _____ Divorced _____

Employer: _____ Occupation: _____

Address: _____ Work Phone: _____

City, St., Zip: _____ Drivers License #: _____

Date last worked: _____ Has your employment terminated? _____

Name of spouse or legal guardian: _____

Employer: _____ Birth Date: _____

Address: _____ Work Phone: _____

City, St., Zip: _____ Social Security #: _____

May we leave voicemail messages regarding your appointments at the following?

Home: Yes _____ No _____ Work: Yes _____ No _____ Cell: Yes _____ No _____

Email address: _____

How did you learn of our practice?

Doctor: _____ Family/Friend: _____ Insurance: _____ Internet: _____ Other: _____

Emergency Contact: _____

Relationship: _____ Phone Number: _____

Type of Payment? Insurance _____ Cash _____ Workers Comp _____

Is condition due to one of the following?: Work Related: _____ Auto Accident: _____

Other; Please Describe: _____

PATIENT HISTORY

Please completely fill out the following questions. This will assist us in properly treating you and identifying possible contraindications for certain treatments. All information is held in strict confidence.

Name: _____ Date: _____

Birthdate: _____ Occupation: _____

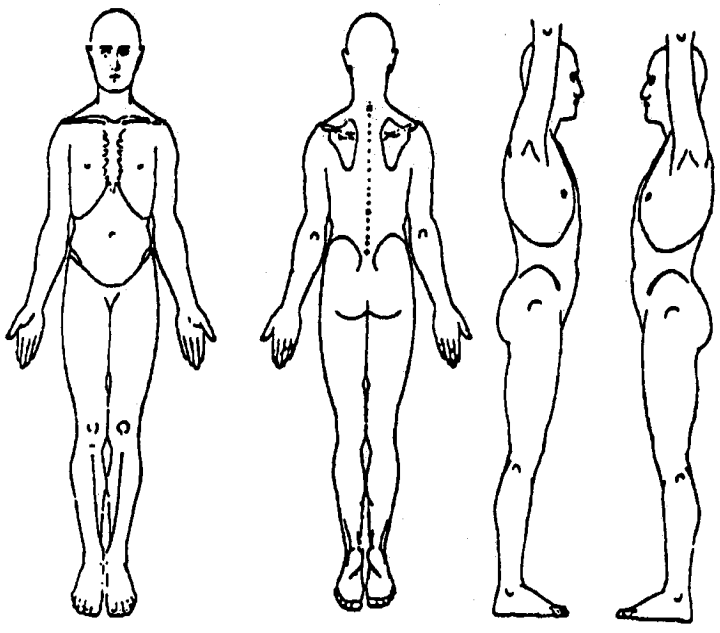
Date of injury or onset of complaint(s):_____
_____

Briefly describe how you were injured or how complaints began (i.e. after tennis, bending....):
_____
_____

Where is your pain / injury located?

_____

Please use the drawings to indicate the location of your pain/injury.



List all over-the-counter and prescription medications you are currently taking for any reason: (include pills, injections, skin patch, etc.)
_____
_____
_____

If you have any metal or other implants in your body, please describe where they are:
_____
_____

Have you had any treatment for this condition? Yes ___ No____

If yes, please describe: _____

Most insurance plans have a maximum benefit for outpatient physical therapy services that may be combined with other therapy services. We will help you monitor your visits, but we will need to be made aware of any previous treatment you may have had. Please check if you have received any of the following services this year:

_____ Chiropractor _____ Physical Therapy _____ Occupational Therapy _____ Speech Therapy

Please check any of the following diagnostic studies completed for this condition:

☐ X-Ray ☐ Electromyography (EMG) ☐ MRI

☐ Computed Tomography (CT Scan) ☐ Other

Have you ever been diagnosed with any of the following: (Circle YES or NO for each item)

YES NO Cancer If YES, please describe: _____

YES NO Heart Attack

YES NO Other Heart Condition, If YES, please describe: _____

YES NO Pacemaker
YES NO High Blood Pressure
YES NO Respiratory Problems
YES NO Asthma
YES NO Emphysema
YES NO Thyroid Problems
YES NO Diabetes
YES NO Multiple Sclerosis
YES NO Rheumatoid Arthritis
YES NO Other Arthritic Conditions
YES NO Stroke
YES NO Deep Vein Thrombosis (blood clot)
YES NO Other

YES NO Kidney Disease
YES NO Anemia
YES NO Epilepsy
YES NO Eye / Vision Problem
YES NO Emotional / Psychological Problems
YES NO Sleep Problems
YES NO Headaches
YES NO Hepatitis
YES NO Tuberculosis
YES NO Osteoporosis
YES NO Pregnant or think you might be.
YES NO HIV

If YES, please describe: _____

Please list any surgeries or other conditions for which you have been hospitalized, include the approximate date and the reason for the surgery or hospitalization.

Date	Surgery / Hospitalization	Reason

Do you smoke tobacco? Yes ☐ No ☐ If yes, how much per day? _____

What are your goals for physical therapy? _____

_____

_____

TAG Physical Therapy Office Policies

Consent for Care and Treatment: I, the undersigned, do hereby agree and give my consent for TAG Physical Therapy to provide physical therapy care and treatment necessary and proper in evaluating and treating my physical condition.

Consent for Treatment of a Minor: As parent and/or legal guardian, I authorize TAG Physical Therapy to treat the minor patient named in the attached consent form while I am not present.

Benefit Assignment/Release of Information: I hereby assign all medical benefits to which I am responsible to TAG Physical Therapy. I hereby authorize TAG Physical Therapy to release all information necessary, including medical records, to secure payment.

Workers' Compensation Claims: If I claim Workers' Compensation benefits and am subsequently denied such benefits, I may be held responsible for the total amount of charges for services rendered

_____

Patient Signature **Date**

TAG PHYSICAL THERAPY

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

TAG PHYSICAL THERAPY'S LEGAL DUTY

TAG Physical Therapy is required is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

TAG Physical Therapy uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, TAG Physical Therapy may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

TAG Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, TAG Physical Therapy's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop further disclosures at any time.

TAG Physical Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. TAG Physical Therapy will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that TAG Physical Therapy may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our owner(s) at the address listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. For further information on TAG Physical Therapy's health information practices, or if you have a complaint, please contact the following:

TAG PHYSICAL THERAPY
111 Penn Street, El Segundo, CA 90245
CATHY TARTE or MINDY GARVEY
(310) 426-9570 (310) 426-9572 Fax
May 1, 2006

PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand TAG Physical Therapy's Notice of Information Practices. I understand that TAG Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that if I notify the practice, I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations. I also understand that TAG Physical Therapy will consider requests for restriction 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 purposes as noted in TAG Physical Therapy's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time

_____
Patient Name

_____
Signature

_____
Signature of Parent/Guardian
(If patient is a minor)

_____
Date