ASSIGNMENT OF BENEFITS TO LIFESPAN PHYSICAL THERAPY SERVICES, P.C.

Patient Name:_____ DOB_____ID#_____

Insurance Policy #_____

Insured Name _____ Insured Date of Birth _____

Your relationship to the Insured _____

Claim # _____

I hereby instruct and direct _____insurance company to pay by check made out and mailed to :

LifeSpan Physical Therapy Services, P.C.
858-412-9349

If my/this current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and **mail it to the above address** for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over this insurance payment.

(Check each box and sign at the bottom)

☐ A Photocopy of the Assignment shall be considered as effective and valid as the original.

☐ I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.

☐ I authorize the use of this signature on all insurance submissions.

☐ I authorize LifeSpan Physical Therapy Services, P.C. to deposit checks made in my name.

☐ I authorize LifeSpan Physical Therapy Services, P.C. to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

☐ I understand that I am financially responsible for all charges whether or not paid by insurance.

Dated this _____day of _____, 20_____.

Signature of Policyholder _____ Witness _____

Signature of Claimant, if other than Policyholder _____

Office Payment Policy

We would like to make the billing and payment process for services as simple as possible for you. Please read the following information regarding the financial policies of this office. Initial the source of payment indicating how our services will be reimbursed.

_____1. **PRIVATE INSURANCE** (PPO): Some Insurance plans require authorization or a referral from your primary physician. Most insurance plans a patient responsibility (deductible or amount paid by the patient before the insurance policy begins payment for services) and/or co-pay (set dollar amount per visit) or coinsurance (a percent of the allowed charges). Deductibles, co-pay and coinsurances, are due at the time of service. Should your insurance deny coverage, we will bill you for the outstanding amount.

_____2. **MEDICARE**: LifeSpan Physical Therapy Services, P.C. is a Medicare Provider. Medi-Gap insurance covers the patient portion until your Medicare benefits are exhausted. Some secondary insurance plans cover the portion due and services after Medicare benefits are exhausted, but not always. All Medicare covered patients are subject to an annual deductible and a cap to physical therapy benefits.

_____3. **WORKERS' COMPENSATION:** Authorizations from your insurance adjuster is required before you can begin treatment. Please ask for an additional form to fill out pertinent information.

_____4. **PERSONAL INJURY or MOTOR VEHICLE ACCIDENT**: If you were in an accident that may be the responsibility of another party, you have two options: (1) make consistent payments as you receive treatment, or (2) sign a lien agreement which will allow you to delay payments until after settlement of your case. You are responsible for your entire treatment cost regardless of settlement amounts/outcome. If you are represented by an attorney, you must disclosed their information and ensure open communication throughout the history of your case.

_____5. **NO INSURNACE (CASH):** If you do not have insurance or do not wish Lifespan Physical Therapy Services, P.C. to bill your insurance for you, you will be expected to pay for treatment at the time you are treated. Cash, check and credit/debit cards are accepted for payment. Our "cash" rates will be provided to you in writing.

_____6. **DURABLE MEDICAL EQUIPMENT (DME) AND SUPPLIES**: DME and supplies are not reimbursable by insurance companies and must be paid for at the time of your therapy session.

_____7. **PAYMENT**: Payments, co-payments and/or co-insurance are expected when services are rendered (each visit). If arrangements are necessary, please contact us directly. We accept VISA, MasterCard, American Express, Discover, debit cards, checks and cash. We expect co-insurance to be paid in full within 30 days from the last day of treatment.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION REGARDING MY FINANCIAL OBLIGATION TO LIFESPAN PHYSICAL THERAPY SERVICES, P.C.

Patient's Name (print)_____

Patient (Guardian) Signature_____Date_____

Credit Card Authorization

Per the policies described herein, we ask that you authorize us to automatically charge your portion of the bill to your Visa, MasterCard, Discover or American Express.

I hereby authorize: **LifeSpan Physical Therapy Services, P.C.**

To apply my balance to my credit card account:

Visa MasterCard Discover American Express

Account Number:_____ Expires: _____ Security Code:_____

Cardholder's Signature:_____ Date: _____

MEDICAL HISTORY

LIFESPAN PHYSICAL THERAPY SERVICES, P.C.

Name:_____ Date:_____

Age:_____ Date Symptoms Began:_____

Please describe any hospitalizations, major surgeries or illnesses you have had in the past 3 years:

_____

_____

List all medications you are taking now:_____

Please use a check mark to indicate when you had any of the following symptoms or diseases.

General Health History:	***YES***	***NO***	***COMMENTS***
Migraine Headaches	☑	___	_____
High Blood Pressure	☐	___	_____
Dizzy Spells	☐	___	_____
Diabetes	☐	___	_____
Epilepsy	☐	___	_____
Heart Problems	☐	___	_____
Pace Maker	☐	___	_____
Lung Problems	☐	___	_____
Circulatory Problems	☐	___	_____
Stroke	☐	___	_____
Cancer (type)	☐	___	_____
Hepatitis (type)	___	___	_____
HIV/AIDS	___	___	_____
Osteoporosis or Osteopenia	___	___	_____
Rheumatoid Arthritis	___	___	_____
Degenerative Arthritis	___	___	_____
Weight Loss or Gain	___	___	_____
Numbness in Legs or Arms	___	___	_____
Numbness in Genital Region	___	___	_____
Change in Sleep due to Pain	___	___	_____
Pain with Coughing or Sneezing	___	___	_____
Change in Bladder Control	___	___	_____
Sensitivity to Heat or Cold	___	___	_____
Allergies	___	___	_____
Female: Pregnant?	___	___	_____

Please describe any past or present joint injuries or diseases:_____
_____

Please describe your current occupation and job duties that you are currently unable or having difficulty performing due to your symptoms:

_____

Please describe any current social or physical activities that you have limited or stopped due to your symptoms:_____

_____

The above information is correct to the best of my knowledge. _____
Signature of Patient

Reviewed By Physical Therapist:_____ Date:_____

Physical Therapy Pre-Exam Questionnaire

Email: office@lifespanpt.com | ph: 858-412-9349 fax: 619-568-3313 | www.lifespanpt.com

LIFESPAN PHYSICAL THERAPY SERVICES, P.C.

In order to evaluate your condition fully, please be as accurate as possible. Thank you.

Patient Name:_____Date:_____

Age:_____ Height:_____ Weight:_____Gender: ( ) Male ( ) Female

1. What is your occupation? _____
- Are you working now? **Yes** **No**

2. Have you had physical therapy before? _____

3. Where is your pain/problem? _____

4. What caused your pain/problem? _____

5. Approximately when did it start? _____

6. Is it getting worse, better or staying the same? _____

7. Have you ever had this pain/problem before? **Yes** **No**

8. Is your pain constant? **Yes** **No**

9. Are you taking any medication for this pain/problem? **Yes** **No**

-If yes, what and does it help? _____

10. Are any of your usual everyday activities affected? **Yes** **No**

-If yes, describe how. _____

_____

11. List all past surgeries with dates:

12. List all medical conditions you have (or were told you have):

NOTICE OF PATIENT INFORMATION PRACTICES

Email: office@lifespanpt.com | ph: 858-412-9349 fax: 619-568-3313 | www.lifespanpt.com

LIFESPAN PHYSICAL THERAPY SERVICES, P.C.

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.

LifeSpan Physical Therapy Services, P.C. LEGAL DUTY

LifeSpan Physical Therapy Services, P.C. 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.

Some examples of how LifeSpan Physical Therapy Services, P.C. may use your personal health information are (but not limited to):

1) To contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you;

2) To discuss your condition over the phone, by fax and/or by mail, with you, another health care provider, or a family member;

3) To discuss you condition or treatment program during the training of Physical Therapy Interns (students that are currently in an accredited physical therapy program);

4) To E-Billing Solutions, our current health care clearinghouse, that translates a claim from a non-standard format into a standard transaction on our behalf and forwards the processed transaction to a payer;

5) To obtain payment or to be reimbursed for services provided to you from your health plan (such as calling for benefits verification/authorization, deductible information, billing, and collection follow-up activities);

6) To conduct quality assurance reviews which helps us improve how we deliver care (quality and length of rehabilitation), case management, and for business management purposes such as analyzing health care costs and staffing appropriateness;

7) To act as a liaison between you, the patient, and another health care provider on your behalf, for the purposes of acquiring durable medical equipment and supplies. Some examples of this include crutches, lymphedema pumps, home traction units, T.E.N.S units, electrodes, and splints.

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

In any other situation, LifeSpan Physical Therapy Services, P.C. policy is to obtain your written authorization before disclosing your personal health information. If you provide us with written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

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

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your 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 you 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 case of an emergency. LifeSpan Physical Therapy Services, Inc. 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 LifeSpan Physical therapy Services, P.C. 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 practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on LifeSpan Physical Therapy Services, P.C. health information practices or if you have complaints, please contact the following person:

LifeSpan Physical Therapy Services, P.C.
office@lifespanpt.com
Phone: 858.412.9346 Fax: 619.568.3313

ACKNOWLEDGEMENT OF PATIENT INFORMATION PRACTICES

LIFESPAN PHYSICAL THERAPY SERVICES, P.C.

I have read and fully understand LifeSpan Physical Therapy Services, P.C. Notice of Information Practices. I understand that LifeSpan Physical Therapy Services, P.C. 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 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 LifeSpan Physical Therapy Services, P.C. will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby acknowledge the use and disclosure of my personal health information for purposes as noted in LifeSpan Physical Therapy Services, P.C. Notice of Information Practices. I understand that I retain to revoke this consent by notifying the practice in writing at any time.

_____
Patient Name

_____
Patient Signature

_____
Date