VERT SPORTS THERAPY & REHABILITATION | 3011 WILSHIRE BLVD, SANTA MONICA, CA 90403

PHONE: 310-264-8385 | FAX: 310-264-9076 | WWW.VERTFITSANTAMONICA.COM

*****All Fields Required** **Patient Information Form**

Patient Name:___________________________________ E-mail:____________________________

Cell #:(____)_______________ Home #: (____)____________ Work #: (____)_________________

Appointment Reminder Type: Call Email Text None
For text reminders, please provide your mobile carrier (i.e. Verizon, Sprint):_____________________________

Home Address:____ Apt/Unit #:_____________

City:_______________________________ State:________________ Zip:________________

Date of Birth:________________________ Age:______ Height: ________ Weight: ________

Social Security:_______________________ DL#:______________________

Works Fulltime: Y/N Homemaker: Y/N Student: Y/N Retired: Y/N Unemployed: Y/N

Employer Name/Job Title:____

Employer Address:____

Emergency Contact:____________________________ Relation:___________________________

Cell #:(_______)______________________ Other phone #:(_______)________________________

How did you hear about VERT?: Doctor Internet Yelp Friend Other:__________________

Referring Doctor:_____________________ Doctor Location:___________________________

Who is responsible for this bill (other than your insurance co.)? ____________________________

Please Select an Option:

1) I would like to pay my patient responsibility each time I come to VERT ☐

2) Please place a credit card on file and charge me automatically each time ☐

Credit Card #:______-______-______-______ Exp.___/___ V-Code______ Billing Zip _________

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I understand that payment is due at each visit, unless financial arrangements have been made. I certify that all the information above is correct.

____ ____________________

Patient Signature Date

____ ____________________

Parent/Guardian Signature Date

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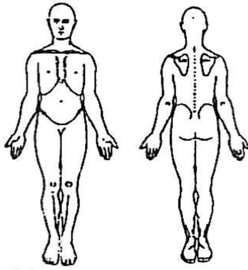
History of Current Injury:



Please shade the areas where you are having your primary pain/discomfort

Please rate your pain: (0= none, 10= worst pain imaginable)

1 2 3 4 5 6 7 8 9 10

Is your pain the result of an injury/accident? Y/N

Briefly describe your injury/pain:

____

____

When did the pain begin?____________________________ Has this happened before? Y/N

Did you go to the emergency room? Y/N X-Rays or MRI was done? Y/N

Who are you/have you seen for this problem? □ Primary care doctor/Internist

□ Sports/orthopedic □ Chiropractor □ Massage therapist □ Acupuncturist

□ Osteopath/physiatrist □ Rheumatologist □ Podiatrist □ Neurologist

Have you had physical therapy treatment in the past for any reason? Y/N

Medical History:

Medications: (Please list dosage and frequency if known.) □ List attached

____

____

Do you have any allergies? Y/N Please list:____

Have you had any surgeries? Y/N Please list:____

Please check if **YOU** currently have or have ever had:

□ Arthritis □ Broken bones/fractures □ Blood disorders □ Circulation/ vascular problems

□ Skin disease □ High cholesterol □ High blood pressure □ Diabetes/ high blood sugar

□ Depression/Anxiety □ Infections □ Parkinson's □ Seizures/epilepsy

□ eye/ear problems □ Kidney Problems □ Lung problems □ Ulcers/ digestion problems

□ Thyroid problems □ Muscular dystrophy □ Osteoporosis □ sleep problems/apnea/insomnia

□ Head injury □ Heart problems □ Stroke □ Multiple sclerosis/ Transverse mylitis

□ Sudden/unexplained weight loss □ Cancer (if yes, what type?______________)

Males: □ prostate problems Females: □ currently pregnant □ trouble/pain with period or pregnancy

Has a doctor ever told you shouldn't exercise because of your health? Y/N

Do you have an implanted pacemaker or defibrillator? Y/N

VERT Sports Therapy & Rehabilitation | 3011 Wilshire Blvd, Santa Monica, CA 90403

Phone: 310-264-8385 | Fax: 310-264-9076 | www.vertfitsantamonica.com

Cancellation Policy

In an effort to better serve you, our cancellation policy is clearly stated below:

- When possible, and out of respect for the therapist and other patients, please do not cancel your appointment.
- If necessary to cancel your appointment please call as soon as possible. There may be other patients who are trying to make appointments that day.
- If you cancel your appointment **more than 24 hours in advance**, there will be no charge to you.
- If you cancel your appointment **less than 24 hours in advance**, but your appointment time is filled by another patient, there will be no charge to you.
- If you cancel your appointment **less than 24 hours in advance** and the appointment is not filled by another patient, you will be charged a **$45 fee late cancellation fee**.
- A missed appointment without a phone call will be an **automatic $45 late cancellation charge**.
- There will be no exceptions for this policy. Thank you for understanding.

I have read the above policy and agree to abide:

______________________________	________________________	__________
Patient Name	Patient Signature	Date
______________________________	________________________	__________
Parent/Legal Guardian Name	Parent/Legal Guardian Signature	Date

Acknowledgement of Receipt of Notice of Privacy Practices

I, ______________________________, have received the Notice of Privacy Practices from VERT Sports Therapy and Rehabilitation facility.

____ ________________

Patient Signature Date

____ ________________

Parent/Legal Guardian Signature (if required) Date

In lieu of patient signature I, **Walter K. Theis M.D.** PT Privacy Director of VERT Sports Therapy and Rehab Facility, state that ______________________________ has been given our current Notice of Privacy Practices.

____ ________________

Signature Date

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Assignment of Benefits

For Direct Payment to VERT, Consent to Release Records, Financial Agreement

I hereby assign and convey all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or equipment rendered or provided by VERT, regardless of its managed care network participation status directly to:

VERT SanFernando Valley Inc 18420 Hart St. Reseda, CA 91335	VERT Physical Therapy LA, LP 12021 Wilshire Blvd., Suite 187 Los Angeles, CA 90025

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

I intend by this assignment and designation of authorized representative to convey to the above-named providers all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance, or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims).

By signing this agreement, I am personally responsible for any and all monies owed to VERT in the event that my said insurance company fails to pay for any or all charges for services rendered.

A photocopy of the assignment shall be considered as effective and valid as the original.

I also authorize VERT to release my records pertaining to treatment rendered here to any insurance company, insurance adjuster or attorney involved in the case.

I authorize VERT to initiate a complaint to the Insurance Commissioner for any reason on my behalf

________________________________ ____________________

Signature of Policy Holder Date

____

Signature of Claimant if other than Policy Holder

________________________________ ____________________

Parent/Guardian Signature (if necessary) Signature of Witness

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Summary of our Notice of Privacy Practices

VERT Sports Therapy and Rehabilitation Facility Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

Please review the full Notice of Privacy Practices (NPP) attached. If you have any questions about this notice please contact Walter Theis, PT Privacy Director at (310) 264-8385.

Who will follow this Notice: VERT Sports Therapy and Rehabilitation Facility
This notice describes our privacy practices. All these entities, sites, and locations follow the terms of this notice. In addition, these entities, sites and locations may share health information with each other for treatment, payment, or health care operations purposes described in this notice.

Our pledge regarding health information:
We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal physical therapist or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this notice of our legal duties and privacy practices with respect to health information about you
- Follow the terms of the notice this is currently in effect.

How me way use and disclose health information about you:
The following categories describe different ways that we use and disclose health information. By coming for care, you give us the right to use your information for treatment, to get reimbursed for your care, and to operate our organization.

These are also various other ways in which we may use or disclose you information

- To allow oversight of the quality of the healthcare we provide
- To allow workers' compensation claims
- As required by subpoena in lawsuits and disputes
- Various uses as required by law or to avert a serious threat to health or safety

The full details for all these uses are contained in the full NPP

Your rights regarding health information about you:

You have the following rights regarding health information we maintain about you:

- Right to inspect and copy
- Right to amend
- Right to an accounting of disclosure
- Right to request restrictions
- Right to request confidential communications
- Right to a paper copy of this notice

Information on how to exercise these rights can be seen in the NPP or can be obtained from Walter Theis, PT privacy director at (310)264-8385

Changes to this notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right corner, the effective date. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with you or with the Secretary of the Department of Health and Human Services. To file a complaint with us contact Walter Theis PT, Privacy Director. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

Other uses of health information

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of care that we provide to you.

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PHONE: 310-264-8385 | FAX: 310-264-9076 | WWW.VERTFITSANTAMONICA.COM

Please initial:

Office Financial Policy And Service Contract

______1. I understand that (VERT Sports Therapy & Rehabilitation) will bill my insurance as a courtesy, but my patient portion (copays for each visit, deductible, and coinsurance for procedures) is my responsibility and due at the time of service. If your staff is unable to determine what my responsibility will be, I will be billed and my payment is due upon the receipt of the first invoice. In order for me to receive services on a credit basis and be billed later for services received, I understand that you require a credit card to keep on file. In the event my account is still outstanding after 31 days, I have been informed my credit card will be charged. (This office policy is an effort to reduce cost related to our collections effort so we can offer you more affordable healthcare overall.) An interest charge of 1.5% per month or 18% per year may also apply to delinquent balances. As well, a 30% charge for accounts sent to a collections agency and additional fees for accounts sent to small claims court. ($5 monthly late fees).

______2. I understand that if (VERT Sports Therapy & Rehabilitation) is contracted with my insurance company, you will apply the contracted adjustment to my claims reducing my costs. If I have Medicare, you will file my secondary insurance. For Both Medicare and other major insurances, I understand your staff will notify me of any services recommended to me that my insurance may not cover. I understand that these non-covered services that may be considered not medically necessary by my insurance are my responsibility and the contracted rate adjustment will not apply.

______3. I understand that if I miss an appointment without giving 24 hours notice to you, I will be charged $45 for that appointment. (Please understand that our office tries to accommodate everyone equally and a missed appointment signifies time we could have scheduled with another patient).

______4. I authorize (VERT Sports Therapy & Rehabilitation) the release of any information to my insurance company, adjuster, or attorney involved in this case.

______5. I authorize release of my medical records and history pertaining to the injury currently being treated by physical therapy to (VERT Sports Therapy & Rehabilitation) including but not limited to notes, reports, and radiological images. Unless otherwise stated, I do not authorize release of any history of sexually transmitted diseases including AIDS or HIV, treatment for drug or alcohol addiction, or mental health treatments.

______6. I have received a copy of the notice informing me of my privacy rights and understand that my health information will be used for treatment, billing, and office preparation.

______7. If my insurance fails to pay my claims in a timely manner, I authorize (VERT Sports Therapy & Rehabilitation) to initiate a complaint to the insurance commissioner for any reason on my behalf.

______8. I authorize payment be made by my insurance company directly to (VERT Sports Therapy & Rehabilitation). If my current policy prohibits direct payment to (VERT Sports Therapy & Rehabilitation), I hereby instruct my insurance company to make out the check to me and mail it as follows: VERT Sports Therapy & Rehab, 3011 Wilshire Blvd, Santa Monica CA, 90403. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

______9. I authorize (VERT Sports Therapy & Rehabilitation) to deposit checks received on my account for services rendered if they are made out in my name.

______10. My Primary insurance company_________________________, is responsible for this bill. I may have secondary benefits with another insurance company, but primary responsibility for my claim is with the_______________________ insurance company.

By signing below, I acknowledge that I've read and accept all terms of the above agreement. I also understand that I'm welcome and encouraged to express all concerns arising out of the financial aspects of my medical care.

______________________	______________________	______________
Patient Name	Patient Signature	Date
______________________	______________________	______________
Parent/Legal Guardian Name	Parent/Legal Guardian Signature	Date

ATTENTION

VERT Westside LP
3011 Wilshire Blvd, Santa Monica, CA 90403
Phone: (310) 264-8385 Fax: (310) 264-9076

Insurance Disclaimer:
"A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits is subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service."

Insurance Liability for Payment:
Your health insurance company will only pay for services that it determines to be "reasonable and necessary". Every effort will be made by this office to have all services and procedures pre-authorized by your health insurance company. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under your plan, your insurer may deny payment for that service.

Beneficiary Agreement:
I understand that if my health insurance company denies payment for the services identified above, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or co-insurance that applies.

______________________	______________________	__________
Patient Name	Patient Signature	Date
Parent/Legal Guardian Name	Parent/Legal Guardian Signature	Date

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INFORMED CONSENT FOR PHYSICAL THERAPY

Dear Patient:

Physical therapy involves the use of many different types of physical evaluation and treatment. At VERT, we use a variety of procedures and modalities to help us to try and improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy.

Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions.

Your physical therapist will discuss what type of treatment he or she is planning based on your history, diagnosis, symptoms, and testing results. Discussion with your therapist will identify what the possible potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time before or during your treatment session.

Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them.

Participant initial here: ________

I agree to the following:

1. My participation in physical therapy and training is strictly voluntary.
2. My participation in each and every exercise and activity within the physical therapy training program is voluntary and I may choose not to participate, or to limit my participation, in any exercise or activity at any time.
3. I am personally responsible for my own safety while participating in the physical therapy program. I will pace myself to maintain a level of participation that is safe and comfortable for me.
4. I will advise my physical therapist/physical therapy assistant/trainer of any changes in my physical or mental health prior to participation in each session.
5. My physical therapist/physical therapy assistant/trainer is available to answer any questions or concerns that I might have regarding my participation, activities, or safety.
6. I will seek further direction or explanation of anything that I do not fully understand, or that causes me concern.

I will allow *VERT Physical Therapy* to record a video of me for treatment purposes: Yes ___ No ___

I acknowledge that my treatment program has been explained by VERT, and all of my questions have been answered to my satisfaction. I understand the risks associated with a program of Physical Therapy as outlined to me, and I wish to proceed.

______________________	______________________	____________
Patient Name	Patient Signature	Date
______________________	______________________	____________
Parent/Legal Guardian Name	Parent/Legal Guardian Signature	Date