Lopez & Associates
Physical Therapy and Sports Rehabilitation

Appointment Date: / / Appointment Time:_____ Date: _____/_____ /_____
Account #:

PATIENT INFORMATION

Name:(Last)_____**(First)**_____**(MI)**____Suffix/nickname:_____

Birth Date:_____ **Sex**:_____**Marital Status:** _____

Address:_____

City: _____**State:** _____ **Zip:** _____

Home Phone:_____**Mobile Phone:**_____ **Work Phone:**_____

Employer:_____**Occupation:**_____

Employer Address:_____ **City:**_____ **State:**_____**Zip:** _____

Work Email Address: _____**Home Email Address:** _____

How did you hear about us?_____

RESPONSIBLE PARTY INFORMATION

Relation to Patient:

Insured's Name: _____ Home Phone: (_____) _____ - _____

Address: _____ Work Phone: (_____) _____ - _____

City: _____ State: _____ Zip: _____ Birth Date: _____ / _____ / _____ Sex: _____

Employer: _____ or Retired

Employer Address: _____ City: _____ State: _____ Zip: _____

FOR OFFICE USE ONLY

Referring Physician or Profile #:_____ UPIN#:_____

Physician Phone: _____ Physician Address_____

City: _____ State: _____ Zip: _____ Services Ordered: PT Body Part:_____

Prescription Date: _____/_____/_____ #Visits Ordered: _____ Specific Orders: _____

Patient Signature ***(certifying that all personal information on this form is correct)*** ***Date***

Lopez & Associates
Physical Therapy and Sports Rehabilitation

FINANCIAL RESPONSIBILITY & COMMITMENT:

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. We are a small business and we rely on timely payments to ensure our operations run smoothly. Please help us help you!

- Office Visit (***patient responsibility***): Deductible, Co-pay, Co-insurance or Cash rate—is ***due in full at the time of the service***. Upon receipt of the patient's EOB (explanation of benefits), and should any portion of the collected amount exceed your patient responsibility, a refund will be processed back to you in the same form of payment.

- Upon receipt of the patient's EOB (explanation of benefits), any Physical Therapy sessions not paid by insurance or collected at the time of visit within 90 days will be invoiced and charged accordingly to you.

- Your scheduled appointment is a verbal contract.

- ***To AVOID our cancellation fee of $75, please call, email or text (310-383-8958) 24 or more hours before your scheduled appointment to cancel or reschedule your appointment. We have patients on our waiting list who would gladly take your slot if given ample notice. Last minute cancellations or no shows are unfair to them and to our business.***

- We accept payment by cash, check, VISA, Mastercard and American Express. An invoice or alert will be sent to you before processing payment on your credit card.

- A credit card number is required for Pre-Authorized Use as disclosed above. This is to collect your payment in a timely manner and to avoid surprise bills from us in the future.

- Inform us at least 24 hours prior to seeing your doctor or surgeon for a follow up visit so we can have a progress note prepared to give to your doctor.

- Inform us of any changes to your insurance or personal information ASAP, especially your credit card information.

- Give us feedback you may have on the service or treatment received.

- Failure to pay any balance due will result in being sent to collections.

I have read, understand, and agree to the above Financial Policy. I understand that visits that are denied by my insurance company, as well as applicable copayments, co-insurance, deductibles, and cancellation fees are my responsibility.

I authorize my insurance benefits be paid directly to Lopez & Associates Physical Therapy.

I authorize Lopez & Associates Physical Therapy to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

Date **Signature** **Printed Name**

Pre-Authorized Use of Credit Card:

I authorize _____ to keep my signature on file and to charge my Visa; Mastercard; American Express; Discover for:

- ***Physical Therapy Session not paid by insurance within 90 days***
- ***Any patient portion, i.e., Deductibles, Co-Insurance & Cash rate***
- ***Cancellation fee policy***

Patient Name Card Holder Name

Cardholder Address

City State Zip

Credit Card Account Number Expiration

Cardholder Signature ***Date***

Email Address (for invoices or receipts)

1426 Aviation Blvd., Suite 204 • Redondo Beach, CA 90278
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Financial Policy Statement

Dear Patient:

We bill your insurance carrier in a timely manner as a courtesy to you. If your insurance carrier fails to remit any payment or denies any claim, you are responsible for the entire bill when the services are rendered.

We require that arrangements for payment of your estimated share be made today. In the event that your insurance company requests a refund of any payments made, you may be responsible for the amount of money refunded to your insurance company pending the outcome of any appeals or resolution process between Ramon Lopez Physical Therapy Inc and your insurance carrier.
If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to RAMON LOPEZ PHYSICAL THERAPY. The above does not apply for those patients that are considered Worker's Compensation. However, be advised if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

I understand an agree that if I fail to make any of the payment for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

ESTIMATED INSURANCE BENEFITS: (Not exact quote)

Estimated patient payment_____

*** Again, we have verified your insurance coverage as a courtesy to you. We encourage patients to call and verify their insurance independently to avoid any financial conflicts in case we are misquoted (as we sometimes are). This may result in other miscellaneous charges that may reflect on your bill. You will be responsible and agree to pay those charges. Initial here if you agree with these terms _____.**

The above information has been read and explained to me. I understand my responsibility for the payment of my account.

Other Comments:

_____ _____
Patient/Guardian Signature Date

_____
Witness Signature

RAMON LOPEZ PHYSICAL THERAPY

Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for RAMON LOPEZ PHYSICAL THERAPY to furnish medical care and treatment to _____ is considered necessary and proper in diagnosing or treating his/her physical and mental condition.

Patient/Guardian_____ Date_____

Benefit Assignment/Release of Information

I, hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and third party payors to RAMON LOPEZ PHYSICAL THERAPY. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

Patient/Guardian_____ Date_____

RAMON LOPEZ 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.

RAMON LOPEZ PHYSICAL THERAPY'S LEGAL DUTY

RAMON LOPEZ 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, RAMON LOPEZ 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.

RAMON LOPEZ PHYSICAL THERAPY 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, RAMON LOPEZ 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.

RAMON LOPEZ 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. RAMON LOPEZ 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 RAMON LOPEZ 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 practice manager 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 RAMON LOPEZ PHYSICAL THERAPY's health information practices, or if you have a complaint, please contact the following person:

RAMON LOPEZ PHYSICAL THERAPY

RAMON LOPEZ PHYSICAL THERAPY

PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand RAMON LOPEZ PHYSICAL THERAPY's Notice of Information Practices. I understand that RAMON LOPEZ 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 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 RAMON LOPEZ 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 RAMON LOPEZ 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

(*OPTIONAL*)
I also authorize RAMON LOPEZ PHYSICAL THERAPY to use my protected health information for targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

_____
Patient Name

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

_____
Date