GASPAR DOCTORS OF PHYSICAL THERAPY

Dear Patient,

We are pleased that you have chosen GASPAR-Doctors of Physical Therapy for your physical therapy needs.

Please take time to fill these forms out completely **prior** to your scheduled appointment so that the therapist can spend the full appointment with you.

On the day of your appointment, please bring:

*Completed Forms

*Insurance Card(s)

*Prescription for physical therapy with diagnosis

PLEASE NOTE: If you have an insurance plan that requires a referral/authorization to see a specialist (such as Health Net HMO/POS, Blue Cross HMO, Blue Shield HMO, Workers Compensation, Primary Care Associates HMO, etc.), please contact your primary physician or medical group to obtain a referral prior to your appointment date.

Please arrive 10 minutes early to allow sufficient time to check-in.

Sincerely,

The team at **GASPAR DOCTORS OF PHYSICAL THERAPY, APC**

Please tell us how you found us

(Please check all that apply)

- ☐ Email newsletter
- ☐ One of our physical therapists
- ☐ A friend
- ☐ A family Member
- ☐ I was a previous patient
- ☐ My insurance company referred me
- ☐ I found you on the internet
- ☐ My doctor referred me
- ☐ Other_____

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PATIENT INFORMATION

****Please present your insurance card for copying****

Patient Name:	Date of birth:	Age:	Gender:
Employment Status (circle one): Employed. Unemployed Retired Student	Email Address:		Marital Status: Single Married Other
Address:	City, State, Zip:		
Home Phone: Okay to leave a message? Yes No	Work/Cell Phone: Okay to leave a message? Yes No	Employer:	
Referring MD		Primary Care MD	
Financial Party (other than the patient)	Relationship:	Home Phone:	Work Phone:
Address:	City, State, Zip:		
Emergency Contact:	Relationship:	Home Phone:	
Address:	City, State, Zip:	Work Phone:	

CANCELLATION POLICY AND CONSENT TO TREAT

We at Doctors of Physical Therapy want to provide the best possible care for our patient and attending your scheduled appointment is a necessary part of the treatment process. If there is not notice of cancellation 24 hours before the scheduled appointment, a $50 cancellation charge will be billed directly to the patient for each cancellation. If you do not show up for a scheduled appointment, this same $50 charge will be assessed.

By signing below, you acknowledged that you have read, understand and agree to abide by our cancellation policy as described. You also acknowledged the above patient information is correct to the best of your knowledge.

I grant permission for the staff of Doctors of Physical Therapy, APC to perform the procedures as prescribed by my physician including a physical therapy evaluation. During the evaluation, the nature of the procedure that will be performed as well as the potential risk of care will be explained to me.

If I become ill, while undergoing treatment. I give permission to the staff to administer treatments which they consider necessary to my well-being. **My signature below indicate that I understand and give consent to be treated as Explained above.**

Patient Signature”	**Guardian Signature (if patient is <18 years old):**	**Date:**
_____	_____	_____

NAME:	AGE:		CONCERN/PROBLEM	DATE OF ONSET	
SECTION ONE-HEALTH HISTORY Have you ever been diagnosed with any following conditions (Fill in appropriate circles)					
1. *Cancer*	YES	NO	Type(s) : include Date of Diagnosis:		
	☐	☐			
2. *Infection*	YES	NO	3. *Cardiovascular*	YES	NO
Chronic Urinary Tract/kidney Infection	☐	☐	Heart Disease	☐	☐
Pneumonia	☐	☐	Pacemaker	☐	☐
Bone/Joint Infection	☐	☐	Arterial Blockage or DVT	☐	☐
Viral Conditions	☐	☐	High Blood Pressure	☐	☐
Other Infection (please list):	☐	☐	Stroke/TIA	☐	☐
			Other	☐	☐
4.General Medical Conditions	YES	NO	Life Factors	YES	NO
Rheumatologic / Arthritic Disorders	☐	☐	Daily Exercise	☐	☐
Heart or Lungs Disorders	☐	☐	Sleep 7-8 Hours Per Night	☐	☐
Pelvic, Incontinence, Urogenital Disorder	☐	☐	Over Ideal Body Weight	☐	☐
Gastrointestinal Disorders	☐	☐	Depression or Anxiety	☐	☐
Neurologic Disorders, Dizziness or Falls	☐	☐	Stress or Headaches(more than 1x/week)	☐	☐
Dermatologic Conditions	☐	☐	Pain Lasting Longer Than Three Months	☐	☐
Allergies	☐	☐	Prior Failed Treatment for Current Problem	☐	☐
Vision or Hearing Difficulty	☐	☐	Belief That Activity Will Worsen Problem	☐	☐
Diabetes	☐	☐	Lack Of Optimism Regarding the Future	☐	☐
Other Condition (please list):	☐	☐	Lack of Support At Home or Work	☐	☐
SECTION TWO - CURRENT MEDICATIONS Please List All Medication Including Frequency and Dosage (Both Over The Counter And Prescribed)					
MEDICATION NAME	FREQ	DOS	*MEDICATION NAME*	FREQ	DOS
1.)			7.)		
2.)			8.)		
3.)			9.)		
4.)			10.)		
5.)			11.)		
6.)			12.)		
SECTION THREE-SURGERIES/HOSPITALIZATION Please List All Pervious Surgeries And Hospitalization You Have Had			**SECTION FOUR-OTHER CURRENT CONDITIONS** Please Fill in Circle		
TYPE/LOCATION	DATE			YES	NO
1.)			Recent, Unplanned Weight Loss	O	O
2.)			Unexplained Night Pain	O	O
3.)			Fever or Night Sweats	O	O
4.)			Nausea / Vomiting	O	O
5.)			Unexplained Weakness or Fatigue	O	O
Section Five-Health Related Habits Please Fill in the circle					
SMOKING	YES	NO	ALCOHOL USE	YES	NO
Do You Smoke?	☐	☐	DO YOU DRINK?	☐	☐
If yes, <1 Pack Per Day	☐	☐	If Yes, <1 Drink Per Day	☐	☐
If yes, >1 Pack Per Day	☐	☐	If Yes, >1 Drink Per Day	☐	☐
SENSITIVITIES	YES	NO	DRUG USE	YES	NO
Are You Latex Sensitive?	☐	☐	Do You Use Drugs Not Listed Above?	☐	☐
Are You Ice Sensitive?	☐	☐	If Yes, Daily	☐	☐
Are You Heat Sensitive?	O	O	If Yes, Occasionally	☐	☐
Prior Physical Therapy	YES	NO	Previous Falls	YES	NO
Please List Details	☐	☐	Please List Dates	☐	☐

I affirm that the above information is correct and true

Patient Signature : **Date:** **Therapist Review (initials) :**

GASPAR DOCTORS OF PHYSICAL THERAPY

Office Payment Policy

It is the policy of Doctors of Physical Therapy, APC. (DPT) that payment is due at the time of service unless other financial arrangements are made in advance. **We require all patients to pay their deductible, co-pay and/or co insurance payment at the beginning of each visit.** The Office Manager at your location will explain this information to you prior to or on your first visit. At the conclusion of your therapy with DPT you may be billed for any outstanding balances.
If you are covered by health insurance with physical therapy benefits, we will be happy to bill your insurance. Please provide your insurance information to the office manager and we will verify your coverage details, as a courtesy. You should NOT assume that employees or contractors of the insurance carrier will always provide Gaspar Physical Therapy with accurate information regarding your coverage. **Therefore, to be safe, you should also contact your insurance carrier and double-check your coverage for physical therapy.** Please remember that you are 100% responsible for all charges incurred: your physician's referral and our insurance verification do not guarantee of payment by your insurance company.
Being referred to our clinic by a physician does not necessarily guarantee that your insurance will cover our services. Do not assume that you will not owe anything if you have more than one insurance policy. You are required to bring in your prescription from your physician, as well as your insurance card prior to being seen. All patient and insurance paperwork must be filled out completely or DPT will charge you as a cash-paying patient.

If you need special payment arrangements, please discuss this with the business manager **before** starting your treatments.

Please initial your payment method and sign below that you have read, understand, and agree with all of the information on this page:

__1. **PRIVATE HEALTH INSURANCE (PPO):** Some insurance plans require authorization or a referral from your primary physician. Most insurance plans have a patient responsibility (deductible or amount paid by the patient before the insurance policy begins payment for services) and/or a co-pay (set dollar amount per visit) or coinsurance (a percent of the allowed charges). **Deductibles, copay, and coinsurance, are due at the time of service.** Should your insurance deny coverage, we will bill you for the outstanding amount.

__ 2. **HMO Insurance:** Authorization from your insurance must be obtained prior to treatment. Any copay of coinsurance is due at the time of treatment. If your HMO plan also has a point of service option you are using, please be sure you understand the difference in your point of service coverage versus your HMO coverage.

__3. **MEDICARE:** DPT is a certified Medicare provider. Medi-Gap insurance covers the patient portion due 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.

__4. **Secondary Medicare Insurance Provider:** _____

__5. **NO INSURANCE (CASH):** If you do not have insurance you may be eligible for an administrative discount if payment is received at time of service. Please notify the office staff that you do not have insurance so that payment plan can be discussed.

__6. **WORKER'S COMPENSATION CLAIMS:** Authorization from your insurance adjuster is required before you can begin treatment. Please provide the office manager with the name and the phone number of your adjuster, the date of your injury and you claim number, and any other pertinent information.

__ 7. **OTHER:** Please list the other type of payment: _____

** Doctors of Physical Therapy, APC. Accepts liens and 3rd Party Payments upon approval by our business manager only!

I have reviewed this office payment policy and discussed it with the office manager. All my questions have been answered to my satisfaction and I understand all the information that has been explained to me.

Patient Signature:	**Guardian's Signature**(If patient is <18 years old)	**Date:**

GASPAR DOCTORS OF PHYSICAL THERAPY

NOTICE OF PATIENT INFORMATION PRACTICES

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

GASPAR DOCTORS OF PHYSICAL THERAPY'S LEGAL DUTY

Doctors of Physical Therapy 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

Doctors of 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, we 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.

Doctors of Physical Therapy may also use or disclose your personal health information without prior authorization for emergencies. We also provide information when required by law. In any other situation, our 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 future disclosures at any time.

Doctors of 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 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.

CONCERNS AND COMPLAINTS

If you are concerned that we many 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 Privacy Officer 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 our health information practices or if you have a complaint, please contact the following person: **Patti Moulds, 700 Garden View Court, Suite 103, Encinitas CA 92024**

******Please retain this copy for your records******

GASPAR DOCTORS OF PHYSICAL THERAPY

ACKNOWLEDGEMENT OF PATIENT INFORMATION PRACTICES

I have read and fully understand Doctors of Physical Therapy's Notice of Patient Information Practices. I understand that Doctors of Physical Therapy may use or disclose my personal health information for 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 hereby consent to the use and disclosure of my personal health information for purpose as noted in Doctors of Physical Therapy's Notice of Patient 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 (Guardian if patient is a minor)

_____

Date