WEST POINT

PHYSICAL THERAPY CENTER

PATIENT INFORMATION

Name: _____ Date: _____

DOB: _____ Sex: M / F S.S.#: _____ D.L.#: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone #: _____ Cell #: _____

Employer Name: _____ Phone#: _____

Address: _____ City: _____

State: _____ Zip: _____ Referring M.D.: _____

Accident Related: ☐ Y / N ☐ Work Related: ☐ Y / N ☐ Date of Injury: _____

Workers Compensation Insurance: _____

Attorney Name: _____ Phone #: _____

Primary Insurance: _____

Secondary Insurance: _____

Assignment and Release

I, the undersigned, have Insurance Coverage with_____
and assign directly to West Point Physical Therapy all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize West Point to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Insured/Guardian **Date**

Medicare Authorization

(Medicare Patients Only)

I request that payment of authorized Medicare benefits be made either to me or on my behalf to West Point Physical Therapy for any services furnished me by West Point. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that with my signature, payment may be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the Physical Therapist or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance's and deductibles are based upon the charge determination of the Medicare carrier.

_____ _____

Beneficiary Signature **Date**

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PHYSICAL THERAPY CENTER

PATIENT HISTORY INFORMATION

Patient Name _____
Last First Middle Initial

Age _____ Height _____ Weight _____ Occupation _____ Date Of Injury _____

Do you do heavy lifting at work? _____ Are you right or left Handed? _____

List all the current medications being taken right now? _____

_____

_____

List the Allergies that you May Have _____

_____

Please Place a **check** in the box if you have been treated for or have a history of the following:

☐ Heart Disease	☐ Lung Disease	☐ High Blood Pressure
☐ Mental / Emotional Problems	☐ Seizures	☐ Circulatory Problems
☐ Ear Problems	☐ Stroke	☐ Eye Problems
☐ Skin Problems	☐ Recent Fractures	☐ Cancer
☐ Numbness/Tingling	☐ Pacemaker	☐ Diabetes

_____ I have not been treated for any of the above listings

Please explain all of the above checked items. _____

_____

Do you have any metal in your body? _____ Explain _____

Are you pregnant? _____

Signature

_____ _____

Signature Date

Palmdale (Main)
1115 West Ave. M-14
Palmdale, CA 93551
(661)265-0060

Cathedral City
68-845 Perez Rd.,
Ste. H6-H7
Cathedral City, Ca 92234
(760)328-0292

California City
9300 N. Loop Blvd.
California City, CA 93505
(760)373-7338

Rosamond
1431 Rosamond Blvd.
Ste. 11
Rosamond, Ca 93560
(661) 256-2700

Indio
81-880 Dr. Carreon Blvd. Ste. A104
Indio, CA 92201-5583
(760)863-0060

INSURANCE ELIGIBILITY WAIVER

I understand that if my eligibility for insurance coverage is not established for any service received from West Point Physical Therapy Center, Inc., I or the person financially responsible for me will assume full responsibility for all charges incurred by myself, and pay in full all such charges.

Signature: _____ Date: _____

NOTICE OF APPOINTMENT CANCELLATION, NO-SHOW & LATE POLICY

I understand that West Point Physical Therapy Center, Inc., requires that any appointment cancellation notice be given 24 hours prior to the scheduled visit, otherwise it will result in the loss of the visit.

I further understand that if I do not show up for two consecutive appointments, without contacting West Point Physical Therapy Center, Inc., it will result in an automatic discharge.

I also understand that if I arrive 15 minutes late or more to my scheduled appointment, I forfeit my visit and will not be seen until my next scheduled appointment.

Signature: _____ Date: _____

NOTICE OF POLICY PRACTICE

I was supplied with West Point Therapy Center's notice of privacy practice, I have read it and understand it's contents. Furthermore, I understand I am entitled to a copy of the original document, which I can ask for at any time.

Signature: _____ Date: _____

NOTICE OF EXCLUSIONS FROM MEDICARE BENEFITS (NEMB)

There are items and services for which Medicare **will not pay**.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you may have to pay for them yourself. **Before you make a decision, you should read this entire notice carefully**. Ask us to explain, if you don't understand why Medicare won't pay. Ask us how much these items or services may cost you.

- Medicare does **not** pay for all of your health care costs. Medicare only pays for covered benefits.
- **Some items and services are not Medicare benefits and Medicare will not pay for them.**
- When you receive an item or service that is **not** a Medicare benefit, **you are responsible to pay for it**, personally or through any other insurance that you may have.

Medicare will not pay for Physical Therapy or Occupational Therapy services over your annual limit ($1,840.00 including deductible and coinsurance).

MEDICARE WILL NOT PAY FOR PHYSICAL THERAPY OR OCCUPATIONAL THERAPY TREATMENT OF YOU ARE BEING TREATED FOR HOME HEALTH SERVICES. NO MATTER WHAT THEY ARE. IT IS YOUR RESPONSIBILITY TO LET US KNOW IF YOU ARE OR BECOME COVERED BY ONE OF SUCH HOME HEALTH SERVICES.

If we provide you additional services once you reach your annual limit, Medicare will not pay since you would be exceeding the financial limitation

Please let us know if you have received Physical Therapy or Occupational Therapy services at another facility since January 1, 2009.

Once your limit is reached, you can choose to continue your treatment in a hospital outpatient facility or **pay yourself** for the services received here.

_____
Medicare Beneficiary Signature

_____
Date