Hello!

How to use this form:

1. Download form to your hard drive.
2. Complete the form. Remember to SAVE AS YOU GO to keep your progress and for your own records.
3. Print the form and bring it with you to your first appointment.

We are committed to providing you with the best possible care. If you have any questions or want to set up an appointment, **please don't hesitate to contact us.** We are here to help you.

Sincerely,

Landswick Physical Therapy, Inc.

LANDSWICK
PHYSICAL THERAPY, INC.

Patient Information

Name: _____ Email: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Home address: _____ City: _____ ZIP: _____

Social Security #: _____ Date of birth: _____

Spouse's name: _____ Phone: _____

Nearest relative not living with you: _____ Phone: _____

Nearest friend not living with you: _____ Phone: _____

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Whom may we contact in case of emergency?

_____ Phone: _____

Whom may we thank for referring you?

_____ Phone: _____

Who is responsible for this bill? _____

I will be paying by: ☐ Cash ☐ Check ☐ Credit card

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 have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature: _____ Date: _____

Parent (if minor): _____ Date: _____

LANDSWICK
PHYSICAL THERAPY, INC.

Insurance Information

Primary insurance: _____ Phone number: _____

Insured's name (if spouse is primary): _____

Insured's date of birth: _____ Insured's Social Security #: _____

Relation to insured (choose one): ☐ Self ☐ Husband ☐ Wife ☐ Other: _____

Secondary insurance: _____ Phone number: _____

Insured's name: _____ ID #: _____

Insured's date of birth: _____ Insured's Social Security #: _____

Worker's comp or auto accident patients (only)

W/C carrier: _____ Phone number: _____

Insured's date of birth: _____ Insured's Social Security #: _____

Claim #: _____ Adjuster: _____ Phone: _____

Is litigation involved? ☐ Yes ☐ No If yes, name of attorney: _____

Attorney's phone: _____ Employer: _____ Phone: _____

Cancellation and late policy

Please be advised of the following policy with regards to appointments and attendance: Cancellations should be done within 24 hours in advance before the appointment is scheduled. **A $45.00 fee applies if cancellation of appointment is not within 24 hours of the appointment time.** Exceptions apply only to illness, family emergencies, etc. See front desk for any questions.

Please arrive promptly for your scheduled appointment to avoid delays in your therapy session. If we cannot accommodate you with the time allotted, we will have to reschedule your appointment. Consistent tardiness will also be subjected to the $45.00 fee if no accommodation is made for you on that day.

Signature: _____ Date: _____

LANDSWICK
PHYSICAL THERAPY, INC.

Assignment of Benefits Form

Date: _____

Patient: _____

Claim # or Group #: _____

Member ID #: _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to:

Landswick Physical Therapy, Inc., 959 E Walnut St, STE 240, Pasadena, CA 91106

or

If my current policy prohibits direct payment to provider, I hereby also instruct and direct you to make out the check to me and mail it as follows:

c/o Landswick Physical Therapy, Inc., 959 E Walnut St, STE 240, Pasadena, CA 91106

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 and above this insurance payment.

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

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

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

_____ _____

Signature of Policyholder Date

Name: _____ Date: _____

Age: _____ Handedness: ☐ Right ☐ Left Sex: ☐ Female ☐ Male

Are you a previous patient? ☐ No ☐ Yes If yes, date of last visit: _____

How did you FIRST hear about our clinic?

☐ Family / Friend ☐ Website ☐ Print ad ☐ Yellow pages ☐ Doctor ☐ Other

If a family member or friend referred you, please provide us with their name and address:

_____

Injury and functional status information

Type of injury: ☐ Work-related ☐ Auto accident ☐ Chronic ☐ Other: _____

I have pain in my *[area(s) of body]*: _____ which is typically

[choose a max of 2] ☐ Shooting ☐ Burning ☐ Aching ☐ Sharp ☐ Dull Other: _____

How often do you have this pain? *[frequency, duration]*: _____

My problem includes *[choose as many as apply]*: ☐ Numbness in my _____

☐ Tingling in my _____

☐ Weakness in my _____

☐ Headaches which occur _____

These specific activites INCREASE my pain: _____

These specific activites DECREASE my pain: _____

Date of INJURY or ONSET of symptoms: _____

Describe HOW this injury occured:

Have you received CHIROPRACTIC or PHYSICAL THERAPY treatments for this injury? Were they helpful?

Describe PREVIOUS INJURIES you have had in this area:

List ALL SURGERIES that you have undergone:

Patient History & Physical Condition Information

Height: _____ Weight: _____

			Details
☐ Y	☐ N	Excessive fatigue of recent onset	
☐ Y	☐ N	Are you pregnant?	
☐ Y	☐ N	Do you have any loss/transplant/impairment of any organ?	
☐ Y	☐ N	Have you had any X-Rays, CAT scans, MRI's etc. in the past year?	
☐ Y	☐ N	Have you been diagnosed with cancer in any area?	
☐ Y	☐ N	Have you had weight loss not associated with a nutritional change?	
☐ Y	☐ N	Is your general health status poor?	
☐ Y	☐ N	Do you have a history of urinary tract infections?	
☐ Y	☐ N	Do you smoke?	
☐ Y	☐ N	Have you had any recent fevers or night sweats?	
☐ Y	☐ N	Do you have a history of falls?	

Do you have irregularities of the following systems?

			Details
☐ Y	☐ N	Head, ears, nose or throat	
☐ Y	☐ N	Circulation (blood clots, poor circulation, etc.)	
☐ Y	☐ N	Eyes (recent change in acuity, blurred vision, etc.)	
☐ Y	☐ N	Musculoskeletal (fractures, sprains, arthritis, etc.)	
☐ Y	☐ N	Neuromuscular (weakness, strains, numbness etc.)	
☐ Y	☐ N	Neurological (stroke, Parkinson's, seizures, etc.)	
☐ Y	☐ N	Skin (rashes, etc.)	
☐ Y	☐ N	Dental (TMJ, etc.)	

Job and Activity Status

I work ☐ Part-time ☐ Full-time ☐ Disability at *[company name]* _____

and my job title is _____

I am a ☐ Homemaker ☐ Retired ☐ Student at *[school name]* _____

If injured at work, with what company were you employed with at the time of injury? _____

If you have work limitations/restrictions what are they? _____

Do you have any recreational activities? _____

Patient Goals

What **ONE** or **TWO** problems would you like your therapist to address within the first **2 WEEKS** of therapy?

What **ONE** or **TWO** problems would you like your therapist to address within the first **6 WEEKS** of therapy?

Progress Reports

We will be preparing an Evaluation report and subsequent Progress reports which will be sent to the doctor that referred you to our clinic.

Would you like us to send a copy of these reports to your family physician? ☐ Yes ☐ No

If yes, please include your family physician's name and address:

LANDSWICK
PHYSICAL THERAPY, INC.

List ALL prescriptions, over-the-counter, herbal, and vitamin/mineral/dietary (nutritional) supplements

Name: _____ Date: _____

Drug/Supplement Name	Dosage	Frequency	Route (Oral, patch, injection, etc.)

(You may continue providing additional information by writing on the back of this page of the form.)

About Financial Arrangements and Medical Insurance

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard, or Visa. We will be happy to help you process your insurance claim-form for your reimbursement. Any such request must be accompanied by a completed insurance form at each visit. In special instances, we may accept assignment of insurance benefits.

Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 11⁄2% per month. Charges may also be made for broken appointments and appointments cancelled without 24 hours advance notice.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however, that:

Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies that pay a percentage (such as 50% or 80%) of “U.C.R.”. “U.C.R.” is defined as usual, customary, and reasonable.

This statement does not apply to companies that reimburse based on an arbitrary “schedule” of fees, which bears no relationship to the current standard and cost of care in this area.

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that, as physical therapy providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding your insurance coverage, PLEASE don’t hesitate to ask us. We are here to help you.

Sincerely,

Landswick Physical Therapy, Inc.

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

This physical therapy practice is required and permitted to make uses and disclosures of an individual's personal health information for purposes of treatment, payment and health operations. It is necessary to share specific and appropriate levels of confidential information about an individual, for example: when submitting claims to insurance companies, retaining records in our office concerning the individual's treatment, or the sharing of information between staff members to process paperwork related to office operations.

Other purposes listed below are either permitted or required to use or disclose confidential information without the individual's written authorization:

a) Uses and disclosures for public heath activities
b) Reporting about victims of abuse, neglect or domestic violence
c) Disclosures for health oversight activities
d) Disclosures for judicial and administrative proceedings
e) Disclosures for law enforcement purposes
f) Uses and disclosures about decedents
g) Uses and disclosures for cadaveric organ, eye or tissue donation purposes
h) Disclosures to avert a serious threat to health or safety
i) Uses and disclosures for specialized government functions. Other uses and disclosures will be made only with the individual's written authorization and that the individual may revoke such authorization.

This office also may contact individuals and may leave messages to provide appointment reminders or information regarding treatment.

The Federal Government has granted patients several new rights under the privacy regulation. They are as follows:

a) The right to request restriction on certain uses and disclosures, for example: an individual may request that this office not leave messages with other family members or on a home voice-mail system regarding certain treatment. Please note that the practice is not required to agree to all requested restrictions.
b) The right to receive confidential communications, for example: on a home voice-mail system.
c) The right to inspect and copy protected health information, for example: clinical records, billing records or other records used to make decisions regarding your care and treatment.
d) The right to amend protected health information, for example: and individual may request information to be amended in their records if he/she feels that it is incorrect.
e) The right to receive an accounting of disclosures of protected health information, for example: disclosures permitted or required by the office to be make in the ordering of a needed medical test.
f) The right of an individual receiving notice electronically to obtain a paper copy of that notice.

This practice is required by law to maintain the privacy of confidential information and to provide individuals with notice of its legal duties and privacy practices with respect to such information; this practice is also required to abide by the terms of this notice; and, we reserve the right to change the terms of this notice and make new notice provisions effective for all confidential information we maintain. Any revised notices will be given to you at this office and a request for your signature on acknowledgement form will be requested.

Individuals may complain to the practice and to the Secretary of the Department of Health and Human Services if the believe their privacy rights have been violated and without retaliation from this practice.

For further information you may contact:
Erik Landswick, MPT
959 E. Walnut Street, STE 240 Pasadena, CA 91106
(626) 795-2390