Asis Physical Therapy
Advanced Solutions • Individualized Service

11848 Bernardo Plaza Ct, Ste. 100, San Diego, CA 92128
1976 Garnet Ave, San Diego, CA 92109
Phone (858) 217-2496 | Fax (888) 493-4898

Dear Patient,

Thank you for choosing Asis Physical Therapy for your physical therapy needs.

Please take the time to fill these forms out completely prior to your scheduled appointment so your Doctor of Physical Therapy 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 a diagnosis
- Comfortable Clothing

PLEASE NOTE: If you have an insurance plan that requires a referral/authorization to see a specialist (such as Tricare or Worker's Compensation), please contact your primary physician or medical group to obtain a referral prior to your appointment date. We are happy to assist you in this process should you require help.

Please arrive 15 minutes early to allow sufficient time for check-in.

Sincerely,

Your Asis Physical Therapy Team

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1. Personal Info

Last Name: _____ First Name: _____ Date of Birth: _____ M / F

Address, City, State, Zip: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____ Email: _____

Occupation: _____ Employer: _____ Phone Number: (_____)_____

Emergency Contact: _____ Relation to Patient: _____ Phone Number: (_____)_____

Work Status: Full Time ____ | Part-time ____ | Retired ____ | Disabled (partial/temporary) _____

Social Security Number: _____ | Married _____ | Single _____ | Student: PART TIME / FULL TIME

My condition is related to: Work _____ | Auto Accident _____ | Sports _____ | Other _____

2. Referral Info

How did you hear about us?

___ Friend, family member, or patient: We appreciate referrals! Make sure to include the name of your referral source so we may send them a thank you: _____

___ Did a doctor refer you? If so, please list their name: _____

___ Web Search & Social Media: Google / Yelp / Facebook / Other: _____

___ Other: _____

3. Consent to Treat

I understand that Asis 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 do hereby consent to such treatment by the authorized personnel of Asis Physical Therapy as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment.

Patient or Guardian Signature _____ **Date** _____

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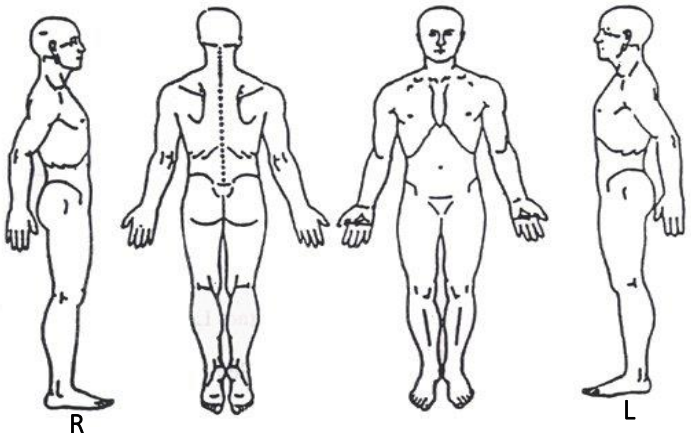
Pre-Physical Therapy Exam Questionnaire

In order to evaluate your condition fully, please be as accurate as possible.

1. Put X's on diagram where you are currently feeling pain:



2. What caused your pain/problem? _____

3. Approximately when did it start? _____

4. Is it getting worse, better, or staying the same? _____

5. Have you ever had this pain/problem before? _____

6. Is your pain constant (never goes away)? _____

7. On the scale below, circle your worst pain level in the past couple of days.

(mild) 0…..1…..2…..3…..4…..5…..6…..7…..8…..9…..10 (severe)

8. Are any of your usual daily activities affected? Yes No

- If yes, describe how: _____

9. Have you had any falls in the past 6 months? If so, when: _____

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Medical History Form

First Name: _____ Last Name: _____ Height: _____ Weight: _____

YES NO Are you under the care of a physician? If yes, please state name and phone number for him/her.

Physician Name:_____ Phone Number: _____

YES NO Have you had any serious illness(es) or hospitalizations in the past five years? If yes, please describe: _____

_____

YES NO Are you now taking any medicine, including non-prescription medication? If yes, what medication(s)? _____

_____

YES NO Have you had any physical therapy services rendered in the last year? If so, where & for what condition? _____

_____

List all past surgeries with dates: _____

_____

Please circle all health conditions that apply or have applied to you within the last 10 years:

YES	NO	Diabetes	YES	NO	GI Disturbances	YES	NO	Immune System
YES	NO	Alcoholism	YES	NO	Stroke	YES	NO	Hearing Problems
YES	NO	Allergies	YES	NO	Heart Disease	YES	NO	Seizures
YES	NO	Anemia	YES	NO	Hypertension	YES	NO	Drug Abuse
YES	NO	Smoker	YES	NO	Respiratory	YES	NO	Liver Disease
YES	NO	Cancer	YES	NO	Visual	YES	NO	Pacemaker
YES	NO	Circulatory	YES	NO	Urinary	YES	NO	Easily Frustrated
YES	NO	Nervousness	YES	NO	Renal Disease	YES	NO	Mental Illness
YES	NO	Depression	YES	NO	Currently Pregnant	YES	NO	Osteoporosis

Do you have any disease or condition not listed above that you feel we should know about? If yes, please explain:

_____

_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth have been answered to my satisfaction by the staff. I will not hold the program or any of its staff responsible for any errors or omissions that I have made in the completion of this form.

Patient or Guardian Signature _____ Date _____

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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 this information. Please review it carefully.

ASIS PHYSICAL THERAPY'S LEGAL DUTY

Asis Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follows the information practices that are described herein.

USES AND DISCLOUSURES OF HEALTH INFORMATION

Asis Physical Therapy uses your personal health information primarily for treatment, conducting internal administrative activities, and evaluation the quality of care that we provide. For example, we may use your personal health information to contact you to provide appointment reminders, information about treatment alternatives, or other health related benefits that could be of interest to you.

Asis Physical Therapy may also use or disclose your personal health information without prior authorization for emergencies, research studies, auditing purposes, and public health/statistical purposes. We also provide information when required by law. In any other situation, our policy is to obtain 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 disclosure at any time.

Asis Physical Therapy may change its policy at any time. When changes are made, a new Notice of Patient Information Practices will be posted in the lobby 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 Patient Information Practice 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 for your records. You also have the right to request a list of instances where we have disclosed 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 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 Billing Manager at (951) 595-1757. You may also want to 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 our office.

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

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Permission to Use Photographs

I grant permission to Asis Physical Therapy, its representatives and employees the right to take and use photographs and/or digital images of me and my property. I agree that Asis Physical Therapy may use such photographs of me with my first name and last initial for any lawful purpose, including publicity, illustration, advertising, and web content including but not limited to use on social media sources such as Facebook, Twitter, Instagram, and Yelp. All negatives, prints, and digital reproductions shall be the property of Asis Physical Therapy.

Printed Name _____

Patient or Guardian Signature _____ **Date** _____

Cancellation Policy

- **Late Policy:** By being late by more than 15 minutes, it is our discretion to either reschedule your appointment or wait for the next available opening. We refrain from appointment overlap because this undeservedly compromises the care of the next patient but we will do our best to accommodate your needs.

- **"No-show" Policy:** Failure to show for 3 consecutive sessions can result in discharge from our care. If you are a Workers Compensation patient, your case manager will be notified about the missed visits and your claim may be discontinued.

- **24-Hour Advanced Notice Policy & Cancellation Fee:** If you need to cancel an appointment, we require a minimum *24-hour advanced notice*. Anything less will result in a *$45 fee* charged to your account. Advanced notice allows another patient to receive care. Please note this fee cannot be billed to your insurance company and will be your direct responsibility and paid upon arrival at your next appointment.

Notice of Patient Information Practices

I have received a copy of the Notice of Patient Information Practices from Asis Physical Therapy or have been able to view this document displayed in the lobby. I understand that this document represents Asis Physical Therapy's legal obligations and practices with respect to my private health care information. I may request an additional copy at any time.

I have read and fully understand Asis Physical Therapy's Cancellation Policy and Notice of Patient Information Practices. By signing below, I am confirming I fully understand these policies.

Patient or Guardian Signature _____ **Date** _____

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Financial Policy

- All payments including deductible, copay, and/or coinsurance are due at the time of service.
- We accept cash, personal check, HSA benefit cards, and credit cards (Visa, Mastercard, and Discover)
- You are 100% responsible for all charges incurred; your physician's referral and our courtesy verification of your insurance benefits are **not a guarantee of payment**.
- Should your insurance deny coverage, we will bill you for the outstanding amount.
- At the conclusion of your therapy with Asis Physical Therapy, you may be billed for any outstanding balances or promptly refunded if there is a positive balance or credit.

Assignment of Benefits

Please select your insurance carrier below:

____ Aetna	____ Anthem Blue Cross	____Blue Shield	____ Blue Shield Federal
____ Care First	____ Cigna	____ Health Net	____ United Healthcare
____ Medicare	____ Medicare Advantage	____ Tricare (Prime/Std)	____ Veterans Choice

____ Other (please list carrier): _____

____ MedPay/Auto Insurance (please list carrier): _____

____ Workers Compensation (please list carrier): _____

____ I authorize Asis Physical Therapy to submit claims to my insurance carrier(s) or third-party guarantor on my behalf. My signature below will be kept on file and acts as a signature on all submitted claims. I authorize direct payment of benefits, otherwise payable to me, to be made payable to Asis Physical Therapy for services rendered.

_____ I authorize Asis Physical Therapy to release any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of continued treatment, processing claims, and securing payment of benefits.

Asis Physical Therapy accepts liens and 3rd party payment upon approval by our business manager only. All visits require a $50 copay due at the time of service

I have read and fully understand Asis Physical Therapy's Financial Policy and Assignment of Benefits. I have provided copies of my insurance cards and by signing below, I am confirming I fully understand these policies.

Patient or Guardian Signature _____ Date _____

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Credit Card Authorization Form

To help save our patients time during the check-in and check-out process, we have acquired HIPAA verified and computer-encrypted technology to store patient credit card information. By filling out this form, it will save you time, decrease landfill by reducing the need to send out invoices and statements via mail, and help lower our costs to ensure we can provide you with the best physical therapy care possible.

Thank you for allowing us to serve you!!

Clinic Locations

Rancho Bernardo
11848 Bernardo Plaza Ct
Ste. 100
San Diego, CA 92128
(858)217-2496

Pacific Beach
1976 Garnet Avenue
San Diego, CA 92109
(858)217-2496

Fax (888)493-4898
E-Mail: info@asispt.com

www.asispt.com

Patient Name: _____

Name as it appears on card: _____

Relationship to the Patient: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Credit Card Type (Please circle one):

Visa MC Amex Discover

Credit Card Number: _____

Expiration Date: _____ Security Code: _____

Email Receipts? Yes No

Email: _____

Next DOS (office use) _____ Amount(office use) _____

Note: Credit cards will be processed within two business days following dates of service and within 2 business days of receipt of EOB's (explanation of benefits) by your health insurance provider.

I, the undersigned customer, acknowledge that I have approved my credit card will be processed for all existing charges acquired while undergoing physical therapy care at Asis Physical Therapy.

Patient or Guardian Signature: _____ Date: _____