737 Pearl Street, Suite 108
La Jolla, California 92037
Phone: 858.456.2114
Fax: 858.456.2103
www.abilityrehabSD.com

PATIENT INFORMATION FORM

Please print and complete ALL items. If an item doesn't apply, put N/A

Patient Name: ______________________________ Age: _____ Sex: _____
Last First Middle

Address: ______________________________
Street City State Zip

Primary Phone: ____________________ Secondary Phone: ____________________

Social Security #: ______________ Date of Birth: __________ Marital Status: _________

Email Address: ______________________________

Spouse's Name: ______________ SS#: ______________ Date of Birth: __________

Spouse's Employer: ____________________ Phone: ______________

***Referring Doctor:* ______________ *Phone:* ______________ *Specialty:* __________**

Primary Care Doctor*:** ____________________ ***Phone: ____________________

How did you find Ability Rehab? ______________________________

Person to notify in case of emergency OUTSIDE of household:

Name: ______________ Home Phone: ______________ Work Phone: ______________

Address: ______________________________
Street City State Zip

Medical History

Have you been treated here or by another physical therapist previously? Yes ______ No ______
If yes, where? ____________________ When? ____________________
Was it for the same condition? Yes _____ No ______ If not, please specify : ______________
____

HAVE YOU RECENTLY RECEIVED ANY TYPE OF HOME HEALTH? Yes _____ No______

Name of Home Health Agency: ______________________________

If you have not been formally released from home health OR are currently receiving home health, please be aware that insurance will not cover both services and you will be responsible for all costs.

***INITIAL:*___________**

PRIMARY Insurance Company: ______________________________ Phone #: (____)______-_______

Policy Holder's Name:____
Last First Middle

Policy Holder's Social Security #:______________________________ Date of Birth: _______________

Address: ____
Street City State Zip

Policy Holder's Employer: ____

Employer's Address:____
Street City State Zip

Position: ____ Phone #: (____)______-_______

Is there Secondary Insurance? Yes _____ No _____

Name of Secondary Insurance Company:____

****

IS THIS A WORKER'S COMPENSATION CLAIM? Yes ___ No ___ Date of injury:____________

****

IS THIS AN ACCIDENT CASE? Yes ___ No ___ VEHICLE ___ OTHER_____________________

****

FINANCIAL POLICY

I hereby agree to pay my account as SERVICES ARE PROVIDED. If for any reason there is a balance owing on my account, I will pay promptly upon receipt of the statement. In exceptional circumstances an extended payment plan may be arranged through our billing department. If so, these arrangements must be completed within 10 days of my initial visit to the office.

I hereby assign all physical therapy benefits to Ability Rehabilitation Specialists (ARS). I understand that if my insurance benefits and/or eligibility are NOT APPROVED by my Health Plan (PPO, Auto, etc.), then I am financially responsible and agree to pay for all charges related to services provided to the patient at ARS. In the event that services deemed medically necessary by your physical therapist are not covered, not authorized or deemed not medically necessary by my Health Plan, then I the Member will be held financially responsible and agree to pay for all the charges related to the services provided by ARS.

Although I have requested Ability Rehabilitation Specialists to bill my insurance company on my behalf, I clearly understand that I am responsible to ARS for payment on my account regardless of the status of my insurance claim.

I hereby authorize Ability Rehabilitation Specialists to furnish information to the insurance carriers concerning my treatment and hereby assign to the therapist(s) all payments for service rendered. I understand that I am responsible for all charges, even those not paid by my insurance. I understand that by signing I am giving my permission for treatment.

Patient's Signature: _________________________________ Date:__________________

Parent or Authorized Representative (if applicable): ____

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CONSENT TO TREATMENT & THERAPEUTIC PROCEDURES

I, ____________________________________, hereby consent to the therapeutic procedures outlined below, to be performed by Ability Rehabilitation Specialists and their associates.

- I agree to be evaluated and treated for functional loss due to related nerve, muscle and skeletal dysfunctions, &/or pain.
- I understand that therapeutic procedures can include but are not limited to joint and soft tissue mobilization; clinic and home exercise programs; functional training including posture and body mechanics; modalities such as heat, ice, e-stim, and ultrasound; and special procedures such as taping.
- I understand that I will be explained the purpose of the therapeutic procedures prior to receiving treatment and that I may refuse any therapeutic procedure at any time.
- I understand that I may consult with other therapists and/or physicians at any time regarding my condition.
- I understand that I may purchase exercise equipment from Ability Rehabilitation Specialists or from any other source.

I certify that I have read and understand the above consent statements:

Patient's Signature: _________________________________ Date:__________________

Parent or Authorized Representative (if applicable): ____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

Patient's Signature: __________________________________ Date: ___________________

Parent or Authorized Representative (if applicable): ____

To ensure you receive the best quality care, staff at Ability Rehabilitation Specialists must speak with other medical professionals and/or personal contacts involved in your care. If there are any other individuals who may be involved in your care that you would like Ability Rehabilitation to be able to communicate with, please list those individuals below:

Examples include family, friends, caregivers, secretaries, transportation company etc.

1) ____
(name and phone number)
2) ____
(name and phone number)
3) ____
(name and phone number)

CONTINUE ON BACK

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PATIENT MISSED APPOINTMENT POLICY

We request that you keep all of your appointments, with the exception of serious emergencies. If you need to re-schedule an appointment we require 24 hours notice. As soon as you are aware of a conflict with your appointment, please call the office immediately and leave a message.

In the instance of a cancellation without 24 hours notice or no-show to a scheduled appointment, we reserve the right to charge you a **$ 50.00** fee.

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

Your adherence to this policy enables us to continue to offer optimal treatment times for you and all of our clients. Please sign below in acknowledgement of this policy.

Patient's Signature: ____________________________________ Date:___________

Parent or Authorized Representative (if applicable): ____