ROZINA & SMITH PHYSICAL THERAPY

846 W Foothill Blvd #C
Upland, CA 91786
T: (909) 985 8686
F: (909) 985-5706
rozinaandsmithpt.com

PATIENT DEMOGRAPHICS

Last Name:_____ First Name:_____ MI:___

Social Security:_____ Date of Birth:_____ Age:_____ Gender:___

Drivers License:_____ Height:_____ Weight:_____

Address:_____ City:_____ State:_____ Zip:_____

Employer Name: _____ Occupation:_____

How did you hear about us? _____

CONTACT INFORMATION

Best Contact Number:_____ ☐ Home ☐Cell
May we leave appointment, billing, or medical information on your answering machine/voice mail? ☐Yes ☐No
☐Leave detailed messages ☐Leave callback information only ☐Leave appointment reminders

Email Address:_____

Emergency Contact:_____ Relationship:_____ Phone:_____
May we leave appointment, billing, or medical information on their answering machine/voice mail? ☐Yes ☐No
☐Leave detailed messages ☐Leave callback information only

MEDICAL HISTORY

Allergies	☐Yes ☐No	High/Low Blood Pressure	☐Yes ☐No	Incontinence	☐Yes ☐No
Asthma	☐Yes ☐No	High Cholesterol	☐Yes ☐No	Parkinson's	☐Yes ☐No
Osteoarthritis	☐Yes ☐No	Cardiac Conditions	☐Yes ☐No	Multiple Sclerosis	☐Yes ☐No
Rheumatoid Arthritis	☐Yes ☐No	Cardiac Pacemaker	☐Yes ☐No	Seizures	☐Yes ☐No
Fractures	☐Yes ☐No	Circulation Problems	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Osteoporosis	☐Yes ☐No	Previous Stroke	☐Yes ☐No	Hepatitis	☐Yes ☐No
Metal Implants	☐Yes ☐No	Diabetes	☐Yes ☐No	HIV/AIDS	☐Yes ☐No
Muscular Disease	☐Yes ☐No	Emphysema/Bronchitis	☐Yes ☐No	Cancer	☐Yes ☐No
Smoking	☐Yes ☐No	MRSA	☐Yes ☐No	Autoimmune Disorder	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	Anemia	☐Yes ☐No	Fibromyalgia	☐Yes ☐No
Dizzy Spells	☐Yes ☐No	Gallbladder Problems	☐Yes ☐No	Hearing Impairment	☐Yes ☐No
Headaches	☐Yes ☐No	Thyroid Disease	☐Yes ☐No	Vision Problems	☐Yes ☐No
Anxiety	☐Yes ☐No	Kidney Problems	☐Yes ☐No	Speech Problems	☐Yes ☐No
Depression	☐Yes ☐No	Currently Pregnant	☐Yes ☐No		

Describe any other conditions or precautions:_____

_____

_____

CURRENT MEDICATIONS

☐ I have provided a written list, see attached

Drug:_____ Dosage:_____ Reason for taking: _____
Drug:_____ Dosage:_____ Reason for taking: _____
Drug:_____ Dosage:_____ Reason for taking: _____

SURGICAL HISTORY

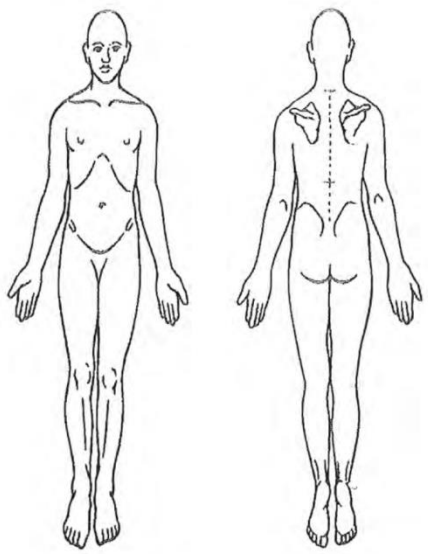
Body Region:_____ Surgery Type:_____ Date of Surgery:_____
Body Region:_____ Surgery Type:_____ Date of Surgery:_____

OTHER SYMPTOMS (If you have not yet seen a physician)

Check all that apply:

☐ Unexplained weight loss
☐ Fever/chills/sweats
☐ Changes in bowel/bladder function
☐ Shortness of breath
☐ Change in appetite
☐ Nausea/vomiting
☐ Difficulty swallowing
☐ Increased pain at night

1. Please circle the number on the intensity scale that best describes your current pain symptoms.
2. Circle or shade the location of your pain on the body chart below.
3. If you have any other symptoms, such as tingling or numbness, draw these as a dotted line.

INTENSITY	PAIN LOCATION
10 Extreme 9 8 7 Severe 6 5 Moderate 4 3 Mild 2 1 0 No Pain	

Please provide a brief history of your injury, such as date of injury, how it started, and any previous treatments.

ACKOWLEDGEMENT

The above information is correct to the best of my knowledge.

Patient Signature:_____ Witness:_____ Date:_____

Parent/Guardian Signature (If patient is a minor):_____ Date:_____

Office Use Only

Patient Physical Therapy Contract

CONSENT TO TREATMENT & THERAPEUTIC PROCEDURES

I, the undersigned, hereby consent to the therapeutic procedures outlined below, to be performed by Rozina and Smith Physical Therapy, Inc. and their associates.

- I agree to be evaluated and treated for functional loss due to related nerve, muscle and skeletal dysfunctions and 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, neuromuscular E-stim and bladder training.
- 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 or treatment 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 Rozina and Smith Physical Therapy, Inc. or from any other source.

OUR FINANCIAL POLICY

- Insurance is a contract between the patient or guarantor and the insurance company; Rozina and Smith Physical Therapy only bills insurance as a courtesy to the patient. I am financially responsible to Rozina and Smith Physical Therapy for services rendered.
- I fully understand that Rozina and Smith Physical Therapy may not accept my insurance fees as payment in full. This would lead to my receiving a bill for deductibles, co-payments, co-insurance and non-covered items. I agree to pay for any such balance.
- I understand that it is my responsibility to obtain all necessary referrals from my doctor or PCP as required by my insurance company. Prescriptions must be kept current from month to month. In the event that services are rendered and later denied by my insurance company(s) for lack of referral/pre-authorization, I understand it will be my responsibility to pay Rozina and Smith Physical Therapy for services rendered.
- Unless appointments are canceled at least 24 hours in advance, our policy is to charge $30.00 for missed appointments. This charge is not covered by insurance and is your responsibility to pay.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I the undersigned 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.

I certify that I have read and understand all of the above:

_____ _____

Patient/Authorized Representative Name (Print) (Self/Parent/Legal Guardian)

Relationship to Patient

_____

Patient/Authorized Representative Signature

Physical Therapist's Signature: _____ Date: _____

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records. (09/27/20)

Medicare Financial Responsibility Disclosure

Effective January 1, 2025, you are responsible for an annual $257.00 Deductible. (Medicare will only pay for services after expenses exceed $257.00.)

Medicare will pay 80% of the allowable charges. You are responsible for the remaining 20%. If you have secondary insurance coverage and provide us with that information, we will bill your secondary insurance as a courtesy for you. If you do not have secondary coverage or your secondary coverage fails to pay for your services, you are responsible for the payment of the 20%.

If Medicare denies charges because you have other insurance that is considered your primary insurance, you will be responsible for all incurred charges. It is your responsibility to inform us of any other insurance coverage that you may have.

On January 1, 2025, Medicare has a threshold for combined physical, occupational and speech/language therapy set at $2410.00.

This threshold will only apply to therapy services you receive in the following places:

- **A doctor's private practice**
- **An outpatient rehabilitation facility or rehabilitation agency.**
- **A comprehensive outpatient rehabilitation facility (CORF) A skilled nursing facility IF you are an outpatient.**
- **A skilled nursing facility IF you are a resident but Medicare is NOT paying for your stay.**
- **At your home if therapy services are provided by a home health agency and Medicare is NOT paying for your home health care.**

You should check your Medicare Summary Notices, which will tell you how much of the cap you have used. If you have any concerns that your therapy benefits will end while you still need services, please contact our office. We will be happy to help you!

If you have any additional questions, ask one our staff members or contact your Medicare carrier (that number is listed on the front of your Medicare Summary Notice) or call toll free: 1-800-MEDICARE

Medicare Part C (Medicare Advantage or Medicare+ Choice)

Please notify one of our office staff if your Medicare coverage is Medicare Part C coverage. Medicare Part C coverage is also known as Medicare+ Choice and is purchased and administered through a private insurance company and includes HMO, PPO, PFFS, PSO and MSA products. Medicare Part C beneficiaries pay premiums that typically provide them with more coverage than the "traditional Medicare programs" (Medicare Part A and B) at a lower cost. Failure to provide us with this information may result in non-payment of your health claims.

☐ I am covered under a Medicare Advantage or Medicare+ Choice program.

☐ I am NOT covered under a Medicare Advantage or Medicare+ Choice program.

Medicare Home Health Services

Medicare has required that patients receiving certain Home Health Services must have outpatient therapy services consolidated with the Home Health Agency. Failure to provide us with this information may result in non-payment of your health claims by Medicare.

☐ I am receiving Home Health Services.

☐ I am NOT receiving Home Health Services.

Previous Physical Therapy Services

Have you had any Physical Therapy services this year?

☐ Yes If yes, please provide the following:

☐ No Name of clinic: _____

Number of visits:_____

I have read and understand the preceding information regarding the Medicare financial responsibilities disclosure, Medicare rehabilitation services cap and reimbursement regarding clinical supplies. Please submit my claim to Medicare. I understand that you may bill me for items or services not covered by Medicare and that I may have to pay the bill while Medicare is making its decision.

Patient/Guardian Signature:_____ Date:_____

Patient Name: _____

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Name:_____ Date of Birth:_____

Social Security or Drivers License #:_____

I request and authorize **Rozina and Smith Physical Therapy** to release my health care information to the following person(s):

☐ Referring Physician

☐ Other:

Name:_____

Address:_____

_____

This request and authorization applies to:

☐ All healthcare information

☐ Health care information related to the following treatment, condition, or dates: _____

_____

☐ Other:_____

Patient Signature:_____ Date:_____

Parent/Guardian Signature(if minor):_____

THIS AUTHORIZATION EXPIRES 1 YEAR AFTER IT IS SIGNED.
A copy of this form will be considered as valid as the original.