Restor Physical Therapy, Inc

17272 Newhope St # G

Fountain Valley, Ca 92708

Office: 714-754-7268

Recurring Payment Authorization Form

Schedule your payments to be automatically charged to your Visa, MasterCard, American Express or Discover Card. Just complete and sign this form to get started!

Recurring Payments Will Make Your Life Easier:
- It's convenient (saving you time and postage)
- Your payment is always on time (even if you're out of town), eliminating late charges

Here's How Recurring Payments Work:
You authorize regularly scheduled charges to your credit card. You will be charged each visit for the total amount due for that visit. A receipt will be emailed to you and the charge will appear on your bank or credit card statement. You agree that no prior-notification will be provided.

Please complete the information below:

I ______________________________ authorize Restor Physical Therapy, Inc to charge/debit my account
(full name)

for the amount due for each visit of what is my responsibility with my Insurance.

I understand that I will only receive notice of the charge if it exceeds more then what my normal payment may be.

Billing Address ______________________________ Phone# ________________________

City, State, Zip ______________________________ Email ________________________

Email: ______________________________

A receipt will be emailed after every transaction charged to your card.

Credit Card

☐ Visa ☐ MasterCard
☐ Amex ☐ Discover

Cardholder Name __________________________

Account Number __________________________

Exp. Date ____________

CVV (3-digit number on back of card) ______

SIGNATURE ______________________________________ DATE ____________________

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Restor Physical Therapy, Inc in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute the scheduled transactions with my bank or credit card company; provided the transactions correspond to the terms indicated in this authorization form.

Restor Physical Therapy
P.O. Box 8125
Fountain Valley, CA 92728-8125
Office: (714) 754.7268
Fax:(714) 434.7042

Patient Information

Please Print Clearly: **Today's Date:** ____________________

Patient's Name ____

Address ______________________________ City ______________ Zip __________

Social Security Number __________________ Sex: M F Date of Birth: ______________

Employer __________________________ Occupation ______________________________

Employer Address ____________________ City ____________________ Zip ______________

Best Phone Number to contact:

Primary ( ) ______________ Cell Home Work (circle one)

Secondary ( ) ______________ Cell Home Work (circle one)

Primary Physician / Referring Doctor ____

How did you hear about us? (If other than Dr's referral) ______________________________

Are you under 18 and/or a dependent on a guardian's insurance? Yes No

If yes, Guardian's name ______________________________________

Emergency Contact ____________________________ Phone( ) ______________________

Insurance/Billing Information

Please circle and fill out what is applicable

Private Insurance / Medicare

Please provide us a copy of your insurance card (s).

IF WORK OR AUTOMOBILE RELATED:

Insurance Company: __________________________ CLAIM #: __________________________

Employer: ______________________________________ Employer #: ( ) ______________

Date of Injury: ______________________________

Adjuster Name: __________________________________ Adjuster #: ( ) ______________

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT OF SERVICES RENDERED.

Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them, not our office. It is your responsibility to pay the deductible, co-insurance, and any other balances not paid for by your insurance. We will assist you in receiving reimbursement, however, you are solely responsible for the remainder of any balances not paid by insurance.

You will be sent monthly statements, which will reflect any payments made by your insurance company on your behalf. Patient statements will be sent to the address given on page one- it is imperative that our office is notified of any address changes for either yourself or your insurance company so that proper follow up and collection efforts may be completed in a timely manner.

On the occasion of a missed appointment without notification, or notification with less than 24 hour notice before the scheduled appointment time, the patient is responsible for a $50 cancellation fee.

I agree to be financially responsible for all charges. I have read and understand this information.

Restor Physical Therapy, Inc applies a $30 returned check fee on the occasion that a payment is returned due to insufficient funds.

To Our Medicare Patients:
It is a requirement of Medicare that your physician / NPP review, date and sign a Plan of Care written by your therapist every 30 - 90 days to complete certification for initial and continued therapy. A physician/NPP may request the patient come in for an exam prior to certifying the Plan.

Assignment of Benefits:
I hereby authorize payment directly to Restor Physical Therapy, Inc for Physical Therapy and/or Medical Benefits otherwise payable to me for services rendered.

Authorization to Release Information:
I hereby authorize Restor Physical Therapy, Inc to release any information required by my insurance company to process claims.

Patient Name (Print): ______________________________ Date: ________________

Patient Signature: ______________________________

Authorization For Treatment of a Minor:
If patient is under 18 years of age, authorization for physical therapy treatment is granted by a legal guardian of the patient by signing below.

Legal Guardian Name (Please Print): ______________________________

Legal Guardian Signature: ______________________________

Relationship to Patient: ______________________________

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PAST MEDICAL HISTORY FORM

Patient Name: ______________________________ Date: ______________

Are you presently working? ☐ Yes ☐ No   Date of next physician's visit: ___/___/___

Date of injury / onset: ___/___/___ Have you ever had physical therapy for theses symptoms before? ☐ Yes ☐ No

Check which apply to your symptoms:

☐ work related injury
☐ motor vehicle accident
☐ cause unknown
☐ recurrence of previous injury
☐ injury related to lifting
☐ athletic / recreational injury
☐ injury related to falling
☐ other: ______________

Have you had a related surgery? ☐ Yes ☐ No

Do you have, or have you had any of the following?

	Yes	No
Diabetes	☐	☐
Chest / Angina	☐	☐
High Blood Pressure	☐	☐
Heart Disease	☐	☐
Heart Attack	☐	☐
Heat Palpitations	☐	☐
Pacemaker	☐	☐
Headaches	☐	☐
Kidney Problems	☐	☐
Are you pregnant?	☐	☐
Cancer	☐	☐
Osteoporosis	☐	☐
Bowel / Bladder Abnormalities	☐	☐
Urine Leakage	☐	☐
Asthma / Breathing Difficulties	☐	☐
Liver / Gallbladder Problems	☐	☐
Smoking	☐	☐
Other:	☐	☐
Allergies to Aspirin	☐	☐
Allergies to Heat	☐	☐
Allergies / Poor tolerance to Cold	☐	☐
Other Allergies	☐	☐
Hernia	☐	☐
Seizures	☐	☐
Metal Implants	☐	☐
Dizziness / Fainting	☐	☐
Recent Fracture	☐	☐
Surgeries	☐	☐
Skin Abnormalities	☐	☐
Sexual Dysfunction	☐	☐
Nausea/ Vomiting	☐	☐
Ringing in your ears	☐	☐
Rheumatoid Arthritis	☐	☐
Special Diet Guidelines	☐	☐
Hypoglycemia	☐	☐
Stroke/CVA	☐	☐

Have you had any of the following medical or rehabilitative services for this injury or episode?

Treatment	YES	NO
Physical Therapy		
Massage Therapy		
Chiropractic		
Podiatrist		
Neurologist		
Orthopedist		

Tests or Testing	YES	NO
MRI		
X-Rays		
CT Scan		
EMG/NCV		
Myelogram		
Injections		

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Consent to Treatment and Conditions of Treatment

Consent to Treatment: I ____

Consent to the procedures, which may performed during my treatment and care at RESTOR PHYSICAL THERAPY, including emergency treatment or services. These may include but are limited to therapeutic test, treatments and procedures, manipulation, stretching, or exercise treatment or procedures as directed under the general instructions of the Physical Therapist or Aide. I am aware that the practice of Physical Therapy is not an exact science and that no guarantees have been made to me. I authorize my Physical Therapist to take photographs relating to my physical condition as are deemed necessary.

Release of Information: RESTOR PHYSICAL THERAPY is authorized to release any information necessary, including copies of my Therapy and medical records to process payment claims for health care services, which have been provided. Such records may include information of a psychological or psychiatric nature, pertaining to my mental condition or treatment for conditions relating to the use of alcohol or drugs. In addition, I authorize my insurance carrier, employer or person otherwise responsible for payment to provide to RESTOR PHYSICAL THERAPY information necessary to determine benefits or process a claim. This release will be valid for the period of time to process the claim or until consent is revoked by the patient.

Financial Agreement/Assignment of Benefits: I assign any and all insurance benefits payable to me to **RESTOR PHYSICAL THERAPY**. I understand that I am responsible for payment of services rendered by **RESTOR PHYSICAL THERAPY** including excluded services from my insurance either because of the plans deemed such services not medically necessary, or for any other reason including pre-certification requirements, second opinions or preexisting conditions. Should the account be referred to any attorney or collection agency for collection, I understand that I will be responsible for attorney and/or collection expenses. I, the undersigned, state that the information that I have provided **RESTOR PHYSICAL THERAPY** is correct to the best of my knowledge. I acknowledge by my signature that I have read and received a copy of this statement.

______________________________________ Date ____ ______________
Signature of Patient or Representative

______________________________________ Date: ______________
RESTOR Physical Therapy Representative

HIPAA Notice of Privacy Practices

RESTOR PHYSICAL THERAPY
P.O. BOX 8125
FOUNTAIN VALLEY, CA 92728-8125
PHONE: 714-754-7268 FAX: 714-434-7042

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information Uses and Disclosures of Protected Health Information Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you.
2. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission. Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that se patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see vu: We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization.
3. These situations include: as required by Law, Public Health issues as required by law, Legal Proceedings: Law Enforcement.
4. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization. Your Rights Following is a statement of your rights with respect to your protected health information.

5. You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.
6. You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
7. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location.
8. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively i.e. electronically. You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
9. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
10. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice. Complaints you may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us.
11. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. This notice was published and becomes effective on or before April 14. 2003. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with Robin R Wells our HIPAA Compliance Officer in person or by phone at 714-754-7268.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: ____________________ Signature: ______________________ Date: ___________