

Physical Therapy
“ The Science of Healing, The Art of Caring”
Welcome to Fortanasce Physical Therapy / Sports Medicine Center

WELCOME TO OUR CLINIC

On behalf of the entire staff, we would like to welcome you to our clinic. We are pleased to have the opportunity to assist you with your physical therapy care. Our goal is to provide the highest quality and most up-to-date physical therapy treatments available in a professional and caring manner. We are committed to helping you attain your rehabilitation goals while striving to meet our motto, “Achieving Excellence In Patient Care”. It is also our goal to provide you with outstanding service.

We would like to review a few of the office policies with you. We believe this will improve your understanding of how our office works, and will enable you to receive the maximum benefit from the physical therapy treatments you will receive.

Our office policies are as follows:

- Your appointment time begins at the time noted on the appointment card. Our goal is to keep your waiting time, if at all, to less than five minutes.
- Should you arrive past your appointment time, we will do everything we can to ensure you receive the maximum benefit from your program. Please understand our commitment to outstanding service extends to all of our clients.
- It is important to the recovery process that you keep all of your prescribed appointments. Should you need to cancel, kindly give 24 hours advance notice.
- We will call and verify your insurance benefits as a courtesy to you. You should, however, be aware of any limitations or stipulations your insurance may have regarding physical therapy care. We are not responsible for inaccurate or mistaken information from the insurance company regarding your benefits.
- We will provide your doctor with a report of your progress at the time of your follow up visit with him/her. Please notify us of your follow up appointment and any appointment changes that may occur so that we can prepare your report accordingly.

Whether you seek to resume pain free activities at home, work or play, we are confident you will find your experience at the office to be valuable in helping you reach your goals.

Thank you for choosing Fortanasce Physical Therapy. Should you have any questions or comments, please do not hesitate to contact either of us directly.

Yours truly,

Kenneth Mengel, PT, OCS

David Gutkind, PT, OCS

TYPE OF INSURANCE (Please check appropriate BOX)

PPO/POS HMO MEDICARE Work Comp Auto

Self Pay Note: If you are SELF PAYING therapy PAYMENT is due at time of each visit.

How did you hear of us? Friend/ Relative Phone Book Other: _____

Do you wish to receive our PhysFacts Newsletter? YES NO

PERSONAL INFORMATION

Today's Date: _____ / _____ / _____ Date of Injury: _____ / _____ / _____

MARITAL STATUS: Single Married Divorced Widow GENDER: Male Female

PATIENTS NAME: _____
 First Middle Last

DATE OF BIRTH: _____ / _____ / _____ AGE: _____

Note: If you are under the age of 18 yrs. A Parent or Guardian must give consent in order to start treatment.

I, _____ give Fortanasce Physical Therapy consent to treat: _____
as of _____ / _____ / _____. Parent/Guardian signature: _____.

SOCIAL SECURITY #: _____ / _____ / _____ DRIVER'S LICENSE #: _____

E-mail Address: _____

HOME PHONE: (____) _____ - _____ MESSAGE PHONE :(____) _____ - _____

LOCAL ADDRESS: _____
 Street City Zip

PERMANENT ADDRESS: _____
(If different from above) Street City Zip

EMERGENCY CONTACT: _____

Relationship: _____ Telephone#: (____) _____ - _____

EMPLOYMENT STATUS

ARE YOU CURRENTLY EMPLOYED: Yes No (If Yes, please provide the following)

Name of the Employer: _____ Telephone (____) _____ - _____

Address City Zip

If an ATTORNEY is involved with this case, please complete:

Attorney's Name: _____ Telephone: (____) _____ - _____

PHYSICIAN INFORMATION

REFERRING PHYSICIAN: _____ **Telephone:** (_____) _____ - _____

FAMILY PHYSICIAN: _____ **Telephone:** (_____) _____ - _____

SUPPLIES

Fortanasce & Associates, Physical Therapy Center will not bill your insurance company for "Any Supplies". You are required to pay for the supply upon receipt. We will provide you with a receipt that you may turn in to your insurance company if you choose. The therapist will explain the need for such supplies for your specialized care and inform you of any non-covered supply that will be used for your therapy program.

It will be your choice to use this form of therapy. If you do not wish to use this type, please inform your therapist, otherwise payment is due at the time of services.

Supplies include, but are not limited to:

Custom made / pre-fabricated splints used in the hand center.
Orthotics made by your physical therapist, and electrodes used during treatment.

We do not have a money back guarantee on custom-made splints. There will not be any refunds or credit offered.

I, ACCEPT the financial obligations if I choose to use non-covered supplies.

I, DO NOT wish to accept to use these non-covered supplies.

Patient Signature: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____

Consent to Take a Photo

I, _____ give Fortanasce and Associates Physical Therapy permission to take a photograph of me. This photo will be placed inside my Medical chart for identification purposes only. I understand that my photograph will not be used for any promotional or advertisement purposes.

Notice of Privacy Practice

I, _____ (PRINT) have received/had access to Fortanasce and Associates Physical Therapy and Sports Medicine Center's "Notice of Privacy Practice" in accordance with Federal HIPAA guidelines.

Signature

Date Received

THIS SECTION IS FOR MEDICARE PATIENTS ONLY:

Are you currently having any type of *Home Health Services* such as: bathing, medication administration, vital signs monitoring or meal preparation. Please be aware that if you are receiving *Home Health Services, Medicare will not pay for outpatient services such as Physical Therapy or Occupational Therapy.*

If you are receiving Home Health services provided by Medicare, you will not be able to start treatment until you are discharged from such services. In order to be discharged from this service you need to contact your primary physician or referring physician.

Please continue to fill out the information that is requested below, if the above does not apply to you.

Referring Physician: _____ **Date on Prescription** ____/____/____

MEDICARE #: _____ **Effective Date:** ____/____/____

Do you have benefits provided by Medi-Cal program? [] Yes or [] No

I ____ do not have Medicare supplemental insurance.

I ____ do have a Medicare supplement insurance with:

Supplemental / Secondary Insurance: _____ **Phone #** ____ - _____

ID# _____ **Group#** _____ **Plan#** _____

MEDICARE PROGRAM PATIENT CONSENT AND PAYMENT AUTHORIZATION

I request rehabilitation services from FORTANASCE & ASSOCIATES and consent to the treatment ordered by my physician who approves and monitors my care.

I consent to the release of information and a copy of my clinical records to FORTANASCE & ASSOCIATES by any health care provider.

I do not receive Medicare benefits from a managed care organization and I am eligible to receive Medicare Part B benefits from a provider of my choice. I certify that the information given by me is applying for payment under MEDICARE program (Title XV111 of the Social Security Act) is correct. I authorize release of all records required to act on this request and that payment of authorized benefits be made on my behalf.

I, hereby assign payment of any Medicare supplemental insurance benefits to FORTNASCE & ASSOCIATES. In the event the insurance benefits are paid directly to me, I agree to make immediate payment or endorse and send the check to FORTANASCE & ASSOCIATES. If I do not have a secondary insurance, I agree to pay the deductible and /or coinsurance when billed unless other arrangements are made in advance.

Initials _____ Date: ____/____/____

**Acknowledgement Letter
Re: Medicare Benefits**

To: All Medicare Patients

The purpose of this letter is to inform you of your Medicare Part B benefits for out-patient physical therapy and occupational therapy in 2006.

Beginning January 01, 2006 Medicare re-initiated the therapy "cap" (a maximum benefit amount) for out-patient physical therapy and occupational therapy services. This "cap" reverses prior year's Medicare benefits by limiting therapy services at private out-patient clinics to a yearly dollar value. Previously therapy benefits were based on medical necessity.

The new allowable limit is \$1,740 per calendar year for physical therapy and a separate \$1,740 per calendar year for occupational therapy. Of that, Medicare will pay 80 %. The remaining 20% balance is due from you as a co-insurance or from your secondary insurance. This Medicare imposed dollar limit provides you a total of approximately 17 visits +/- per calendar year for all out-patient physical therapy services and another approximately 17 visits +/- per calendar year for all the occupational therapy services you may need. This is not per injury or condition, but per calendar year for all physical therapy and occupational therapy services you may require. With this in effect, it is important that you understand your options.

- 1.) If you decide to have physical / occupational therapy at Fortanasce, Medicare will only allow up to \$1,740 dollars for treatment. After your benefits (\$1,740) have been exhausted, you may elect to pay "out of your pocket" for your physical / occupational therapy care. If you decide to stay at Fortanasce to continue your treatments, payment is expected at the time of your visit. You will not be charged more than what Medicare would allow for the same service.
- 2.) Once your Medicare benefits have been exhausted and you do not elect to "pay out of your pocket" for physical / occupational therapy, then you cannot receive treatment at our clinic. One option would be to join our fitness program (or any gym program of your liking) so you can continue with your exercise routine. Another option is to receive treatment from a hospital based clinic, which is exempt from the benefit limit.

Please sign below, acknowledging that you have read the letter and understand what your Medicare benefits are for out-patient physical/occupational therapy services.

Initials

Date

Witness

Date

ADMISSIONS INFORMATION
Patient Questionnaire

Patient's Name _____ Age _____ Date _____

Date of Injury _____

Medical History

Do you now have/or had any of the following:

Diabetes	Yes___ No___	Sensitive to Heat / Ice	Yes___ No___
High Blood Pressure	Yes___ No___	Pregnant (currently)	Yes___ No___
Heart Disease	Yes___ No___	Other Allergies	Yes___ No___
Heart Attack	Yes___ No___	Previous Surgeries	Yes___ No___
Pacemaker	Yes___ No___	Hernia (Ventral,	
Headaches	Yes___ No___	Inguinal, etc)	Yes___ No___
Kidney Problems	Yes___ No___	Seizures	Yes___ No___
Nervous Disorders	Yes___ No___	Metal Implants	Yes___ No___
Cancer	Yes___ No___	Asthma	Yes___ No___

If yes on any of the above, please explain and give approximate dates: _____

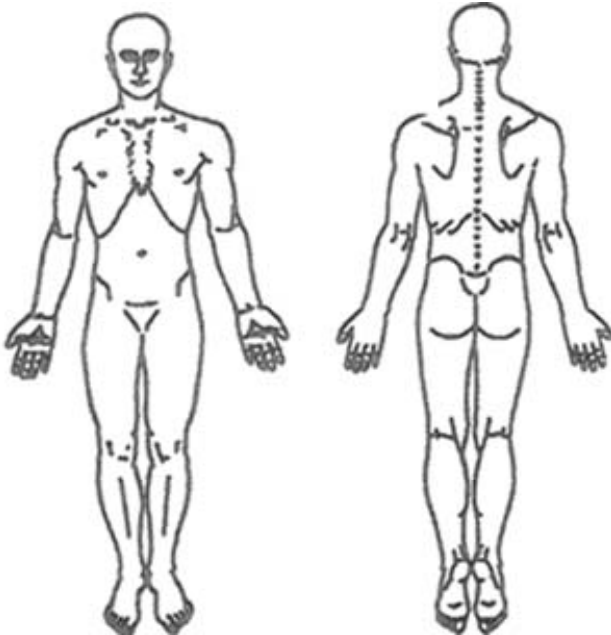
Are you presently taking medications? Yes___ No___ If yes, what medications and for what condition?

Reason for Physical Therapy (include dates and circumstances): _____

Describe your symptoms and / or complaints: _____

Do you have other problems or concerns we should be made aware of? _____

Please shade in areas of concern on the diagrams below indicating where you have Pain, Tingling, Swelling, etc.

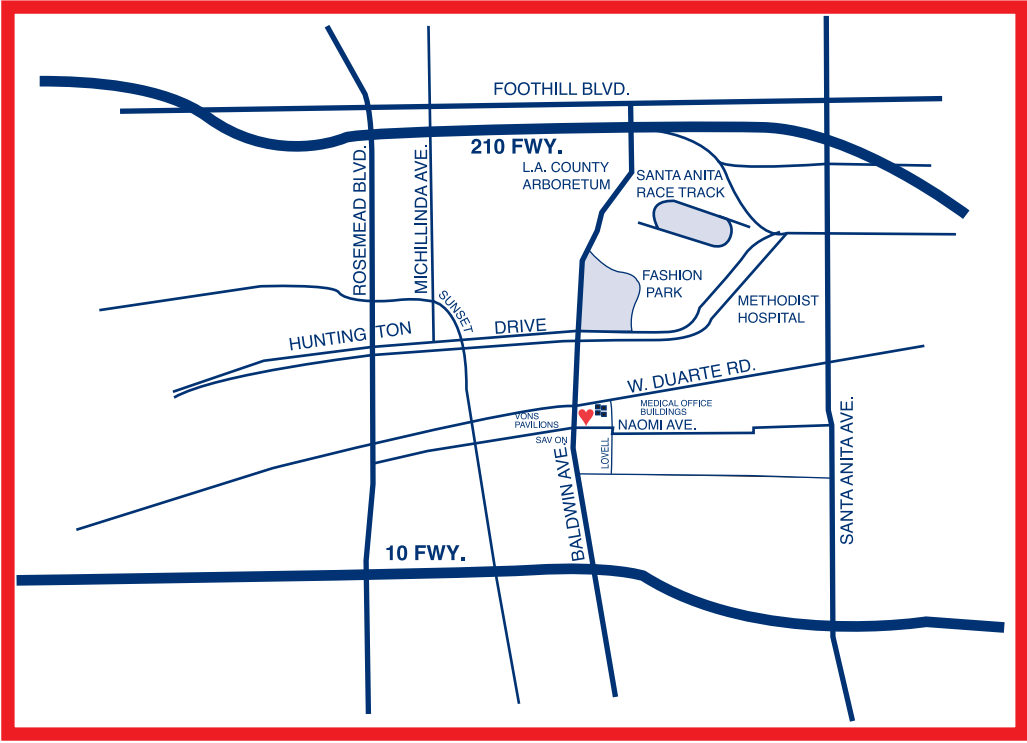


Patient Signature

Fortanasce Office Locations

Arcadia Location

671 Naomi Ave
Arcadia, CA 91007
Phone (626) 446-7027



LaVerne Location

1275 Foothill Blvd.
La Verne, CA 91750
Phone (909) 593-1200

