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: ____.

SOCIALSECURITY#: _________/_______/_______ 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

REFFERING 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*** w*is*h 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 Fortanacse and Associates Physical Thearpy and Sports Medicine Center's "Notice of Privacy Practice" in accordance with Federal HIPAA guidelines.

_______________________________________ _________________________________

Signature Date Received

THIS SECTION IS FOR WORKER'S COMPENSATION PATIENTS ONLY:

If the date of your injury/claim is 1/1/04 or future, Worker's Compensation will only allow 24 visits for the lifetime of your claim. If you have had any type of Physical Therapy/ Occupational Therapy or Chiropractic services these are included into your 24 visit limit. Please be sure that you have all information that is being requested below. If your referring physician has this information, you need to contact their office to obtain All the information.

Referring Physician: ______________________________ Date of INJURY______/_____/_______
Worker's Compensation Carrier: ____
Address: ____
Telephone: (_____) _____________-_________________ FAX (_____) __________-___________
Claim Adjuster: _________________________________ Rehab Nurse: ____________________________
Claim #: ____ WCAB Number: _______________________
Employer Name: ____
Address: ____ Telephone: (_____) __________-___________

ASSIGNMENT OF BENEFITS

I, _______________________________, hereby assign all medical benefits, to include major medical benefits, to which I am entitled to, including Medicare and other government sponsored programs, private insurances, and any other health plans to Michael G. Fortanasce, DT, DPT.

I understand that I am financially responsible for all CHARGES whether or not they are paid by said insurance. I hereby authorize Michael G. Fortanasce to release all information necessary to secure the payment of said benefits.

RELEASE OF INFORMATION

I herby authorize Michael G. Fortanasce, DT, DPT to disclose or obtain all or any part of my or my dependents records to or from any person or corporation which may be liable for all or part of the charges of Fortanasce & Associates including, but not limited to, insurance companies, worker's compensation carriers or employers.

LEGAL COST

I understand that, should Fortanasce & Associates be required to legal action to recover payments for services rendered, I am responsible for all legal and court costs.

Notice of Compliance

It is the experience of our office that employees presenting legitimate work related injuries do not miss scheduled appointments, physical therapy and specialist consultations. Their focus is on getting well, complying with prescribed treatment, and returning safely to the work place as soon as possible. Any patient that is non-compliable with their treatment in our office will be brought to your attention immediately. This section is to notify you that:
Name: ____ has missed appointments for one of the following:
Physical Therapy / Occupational Therapy Date________, _______, _______.
You have been informed that this letter will go to your insurance carrier on all cancelled appointments unless a 24 hours notice is given.

MILEAGE REIMBURSEMENT, I understand that it is ***my responsibility to keep good record*** of my dates of service or I must comply with a service charge of $25.00 for a copy of appointment dates.

Patient Signature: ________________________________ **Date:** _____/_____/______

Witness Signature:________________________________ **Date:**_____/_____/_______

ADMISSIONS INFORMATION
Patient Questionnaire

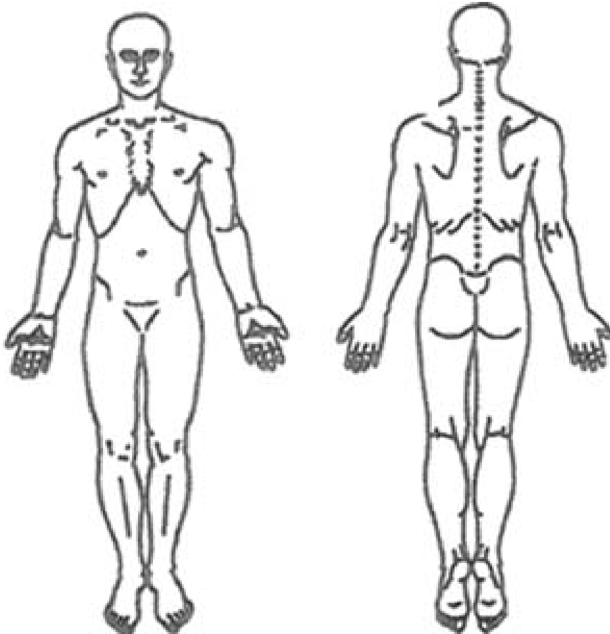
Patient's Name_________________________________ Age ________Date ___________

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.



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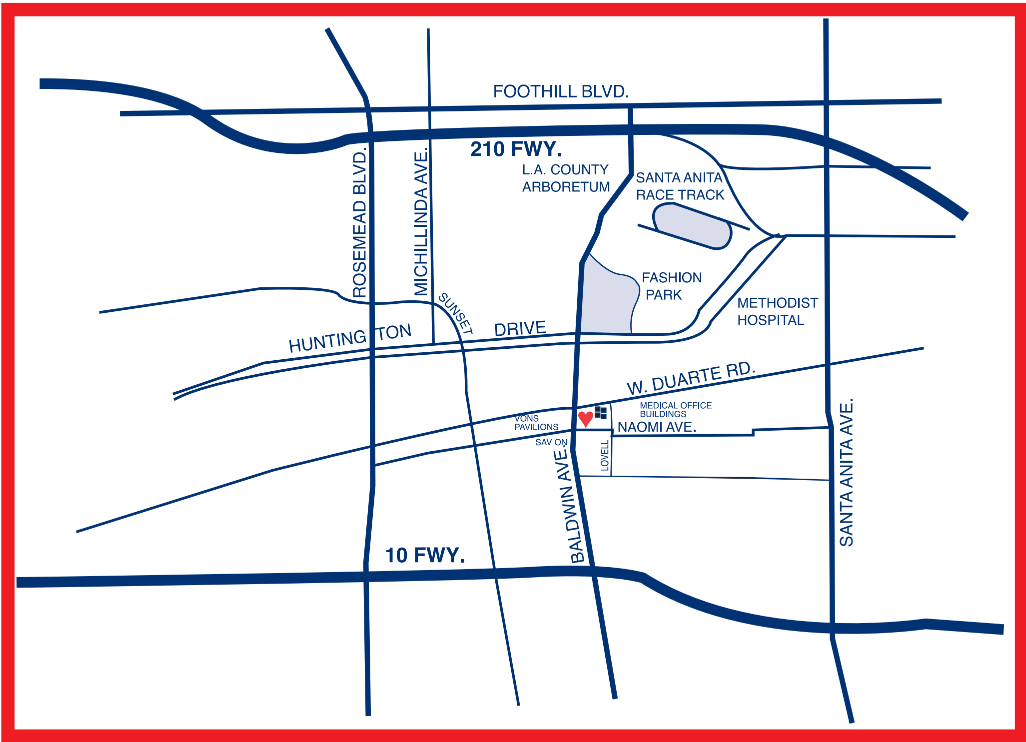
Patient Signature

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