

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

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



FORTANASCE & ASSOCIATES

Physical Therapy/Sports Medicine Center

"Committed to Excellence in Patient Care"

(626) 446-7027 FAX: (626) 446-4723

Michael G. Fortanasce, DPT. A Professional Corporation

INSURANCE INFORMATION

MEDICAL INSURANCE FOR THIS ILLNESS (CHECK THOSE APPLICABLE)

PRIVATE HEALTH INSURANCE NAME OF INSURED _____
OR
INSURANCE COMPANY _____

MOTOR VEHICLE INSURANCE INSURANCE COMPANY ADDRESS _____

GROUP NO. _____ POLICY NO. _____

WORKER'S COMPENSATION CARRIER NAME _____
ADDRESS _____
CONTACT PERSON _____
CLAIM NO. _____ TELEPHONE _____
EMPLOYER NAME _____
EMPLOYER ADDRESS _____

ATTORNEY'S LIEN NAME OF INSURED _____
ADDRESS _____
TELEPHONE () _____

SELF PAYING CHARGES TO BE PAID AT TIME SERVICES RENDERED

FINANCIAL RESPONSIBILITY

Financial responsibility for service rendered rests with the patient or his/her family. At the end of each week's treatment, 20% of charges and services is required. Most insurance carriers will pay 80% of charges submitted. We will provide you with copies of all charges and services for you to submit to your individual carrier for reimbursement (excluding Worker's Compensation). You are responsible for all charges and services that are 30 days or older. After 30 days a 1.5% interest rate will be added to your outstanding balance (18% annual, 19.56% A.P.R.)

CANCELLATION

24 hour notice of a cancellation is required: otherwise, the patient will be charged for the treatment.

RELEASE OF INFORMATION

I hereby authorize Michael G. Fortanasce to disclose all or any part of my or my dependent's records to any person or corporation that 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 COSTS

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

AUTHORIZATION TO PAY BENEFITS

I _____, hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance, and any other health plans to Fortanasce & Associates. I understand that I am financially responsible for charges not covered by my insurance.

NAME: (PLEASE PRINT) _____

SIGNATURE: _____ DATE: _____

NOTE: Any changes to this form must be initialed by both parties.

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: _____

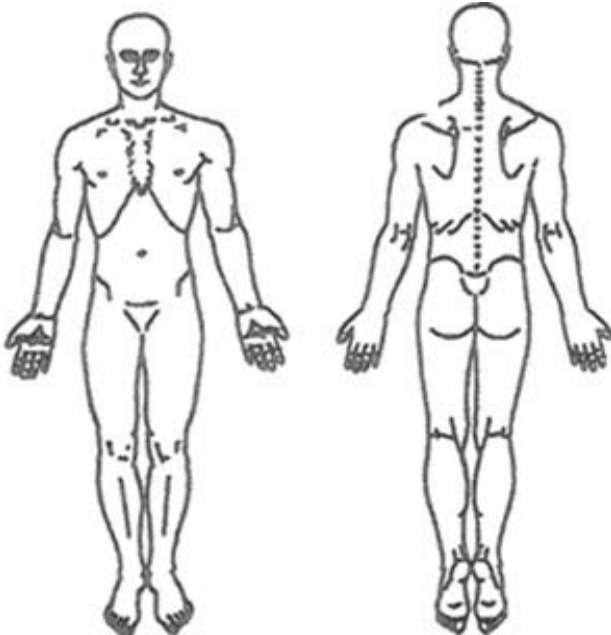
Are you presently taking medications? Yes___ No___ If yes, what medications and for what condition?

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.

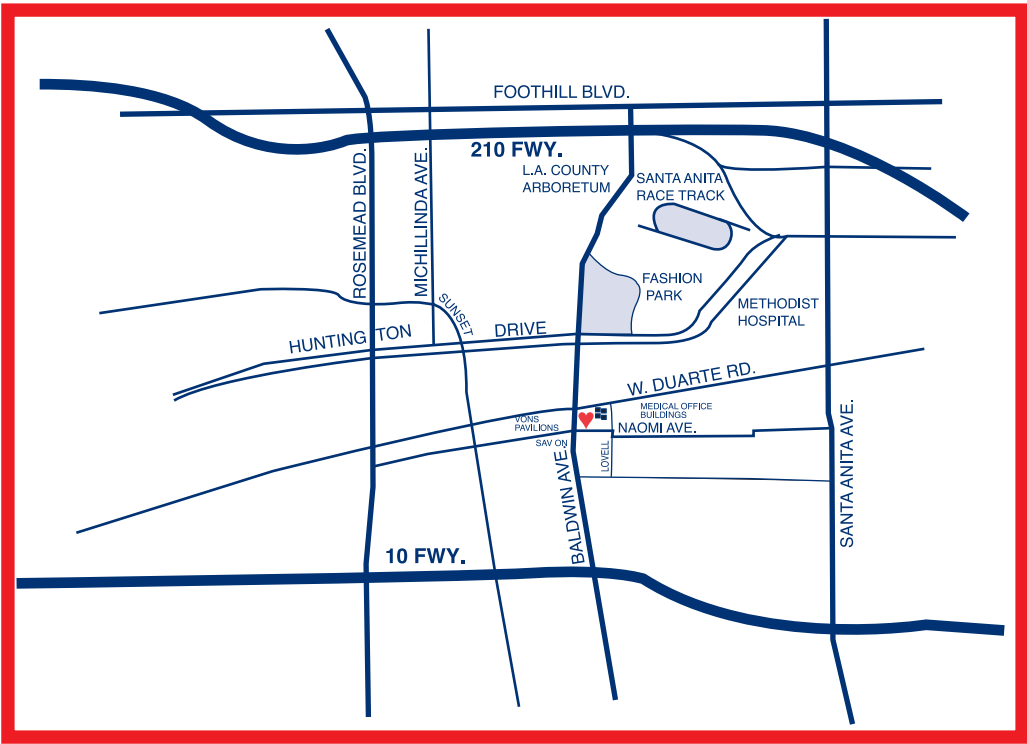


Patient Signature

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

