Thomas Reed Physical Therapy Inc.
Orthopaedic Rehabilitation
& Sports Medicine Centers

Welcome to our Office

GENERAL INFORMATION

NAME____DATE_______________TIME________________
ADDRESS____SEX____________BIRTHDATE_________
CITY/STATE/ZIP ____SSN# ___________________________________
HOME PHONE __________________________________DRIVER'S LICENSE#______________________________
LOCAL FRIEND/RELATIVE _______________________________PHONE (   ) ____________________________
EMAIL ADDRESS____

EMPLOYMENT INFORMATION

CURRENT EMPLOYER __________________________________PHONE (   ) _____________________________
ADDRESS____

PRIVATE HEALTH INSURANCE INFORMATION

HEALTH INSURANCE CARRIER ____________________________________PHONE (   ) _________________
ADDRESS____
NAME OF INSURED ______________________________________GROUP/POLICY # ________________________
RELATIONSHIP TO INSURED __________________________________INSURED'S ID # ______________________

WORKER'S COMPENSATION INFORMATION

EMPLOYER AT TIME OF INJURY ______________________________PHONE (   ) _________________________
ADDRESS ____DATE OF INJURY ____________________________
INSURANCE CARRIER ____PHONE (   ) _________________
ADDRESS ____POLICY # ___________________________________
WCAB CASE # ____CLAIM # ______________________
CLAIMS ADJUSTER____

REFERRED BY: (   ) INSURANCE (   ) EMPLOYER (   ) ATTORNEY (   ) QME EVALUATION
ARE YOU CURRENTLY UNDER A DOCTOR'S CARE (   ) YES (   ) NO
IF YES, NAME OF DOCTOR ____
ADDRESS ____PHONE (   ) _____________________________

AUTO INSURANCE INFORMATION

YOUR AUTO INSURANCE CARRIER _____________________________PHONE (   ) _______________________
COMPLETE ADDRESS ____DATE OF ACCIDENT _____________
NAME OF INSURED ____POLICY # _______________________
CLAIMS ADJUSTER ____CLAIM # ________________________

WORKER'S COMPENSATION OR PERSONAL INJURY ATTORNEY INFORMATION

DO YOU HAVE AN ATTORNEY (   ) YES (   ) NO
ATTORNEY'S NAME ____PHONE (   ) ____________________
ADDRESS____

FINANCIAL AGREEMENT

PATIENT'S NAME (PLEASE PRINT) ____

Please read the information below and where applicable, signature is required

CASH ACCOUNTS
All charges are due and payable at the time of the visit.

Signature ______________________________ Date ______________________

PRIVATE INSURANCE AND MEDICARE ACCOUNTS
All fees are due and payable at the time of service unless other arrangements are made. I fully understand that I have total and direct responsibility to Thomas Reed Physical Therapy Inc. and Orthopaedic Rehabilitation & Sports Medicine Centers for all medical bills submitted by them for services rendered to me. As a courtesy to our patients, we will be happy to bill your insurance company. I fully understand that all charges are due and payable in ninety (90) days and payment is not contingent upon medical insurance payment. Upon duplication of payment by your insurance company, a refund will be issued to you by this office in a timely manner.

Signature ______________________________ Date ______________________

LEGAL ACCOUNTS / LIENS
We require all insurance information (health, automobile) to be furnished to our office. A lien must be signed for the therapist's protection. I fully understand that I have complete and direct responsibility to Thomas Reed Physical Therapy Inc. and Orthopaedic Rehabilitation & Sports Medicine Centers for all medical bills submitted by them for any and all services rendered me. I fully understand that all charges are due and payable to Thomas Reed Physical Therapy Inc. and that payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee.

Signature ______________________________ Date ______________________

WORKERS' COMPENSATION ACCOUNTS
With proper authorization and verification of worker's compensation carrier, we will bill all dates of service to the insurance company. I authorize payment from my worker's compensation insurance company to be paid directly to Thomas Reed Physical Therapy Inc. I understand in the event this injury is proven not to be work-related, I will supply Thomas Reed Physical Therapy Inc. with any private insurance I have which may cover my charges and agree that I am personally responsible to pay for all physical therapy charges that I have incurred.

Signature ______________________________ Date ______________________

AGREEMENT OF BENEFITS

I hereby assign the insurance benefit payments to which I am entitled directly to Thomas Reed Physical Therapy Inc. I understand that I am financially responsible for the charges not covered by the assignment and that any excess payment will be refunded to me.

Insured's Signature _________________________ Date ______________________

Thomas Reed Physical Therapy Inc.
Orthopaedic Rehabilitation and Sports Medicine Centers
Patient Consent for Use and Disclosure
Of Protected Health Information

With my consent, Thomas Reed Physical Therapy Inc. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Thomas Reed Physical Therapy Inc.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy prior to signing this consent. Thomas Reed Physical Therapy Inc. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Thomas Reed Physical Therapy Inc. 22647 Ventura Blvd., Suite #358 Woodland Hills, CA 913647.

With my consent, Thomas Reed Physical Therapy Inc. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice to carry out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

I have the right to request that Thomas Reed Physical Therapy Inc. restrict how it uses or disclosed my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Thomas Reed Physical Therapy Inc.'s use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Thomas Reed Physical Therapy Inc. may decline to provide me treatment.

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Signature of Patient or Legal Guardian

____ ________________________
Patient's Name **Date**

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Print Name of Patient or Legal Guardian

Thomas Reed Physical Therapy Inc.
Orthopaedic Rehabilitation &
Sports Medicine Centers

AUTHORIZATION TO TREAT A MINOR

DATE: ________________________________

RE: ___________________________________

DATE OF INJURY: _____________________

To whom it may concern,

I hereby give permission for the above named patient to be treated by the above referenced facility. By signing this, I am stating that I am the legal guardian and have the authority to give permission for treatment as may be necessary to this minor.

Signature ______________________________

Relationship ___________________________