CUSTOM PHYSICAL THERAPY

"Fit To Your Needs"

325 Rolling Oaks Drive, Suite 210
Thousand Oaks, CA 91361
Phone: (805) 446-3141
Fax: (805) 446-3140

Patient Information

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

Patient's Name _____

Address _____ City _____ Zip_____

Social Security Number_____ Sex: M F Date of Birth: _____

Email Address : _____ Opt Out _____

Employer _____ Occupation _____

Employer Address_____ City _____ Zip_____

Best Phone Number to contact:

Primary ( )_____ Cell Home Work (circle one)

Secondary ( )_____ Cell Home Work (circle one)

Other ( )_____ Cell Home Work (circle one)

Primary Physician / Referring Doctor _____

How did you hear about us? (If other than Dr. 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).

Workers' Compensation

If Work Related:

Worker's Compensation Insurance Company: _____

Employer @ time of injury: _____ Employer #: ( )_____

Date of Injury: _____

Adjuster Name: _____ Adjuster #: ( )_____

Over ->>

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 $40 cancellation fee.

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

Custom Physical Therapy 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 Custom Physical Therapy for Physical Therapy and/or Medical Benefits otherwise payable to me for services rendered.

Authorization To Release Information:
I hereby authorize Custom Physical Therapy 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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Medications

Please list below your current medications

Medication	Dosage	For What Condition

9/25/18

Acknowledgement of Privacy Practices

I have read and acknowledge the notice of Privacy Practices under the Health Insurance Portability & Accountability Act of 1996 for Custom Physical Therapy.

Patient Name_____ **Birth date:**_____

Patient Signature_____ **Date:**_____