CREAMER PHYSICAL THERAPY
7946 IVANHOE AVE SUITE 110, LA JOLLA, CA 92037
TEL: 858 551.8882 FAX: 858 551.0593

PATIENT INFORMATION

NAME_____Tel #(___)_____

STREET_____CITY_____,ST_____ZIP_____.

EMAIL ADDRESS_____
Used for appointment reminders.

DATE OF BIRTH:_____AGE_____SOCIAL SECURITY #_____

MALE OR FEMALE MARITAL STATUS: M S D W

REFERRING DOCTOR:_____

DATE OF ONSET_____DATE OF SURGERY:_____.

DUE TO ACCIDENT? _____Y _____N DATE OF ACCIDENT _____ ATTORNEY ____Y ____N

NAME OF AUTO INSURANCE IF DUE TO MOTOR VEHICLE ACCIDENT_____
ATTORNEY: NAME/ADDRESS/TELEPHONE _____
_____

EMPLOYER_____PH(_____)_____.

STREET_____CITY_____,ST_____ZIP_____.

IN CASE OF EMERGENCY PLEASE NOTIFY

NAME_____RELATION_____PH (____)_____.

CONDITIONS OF FINANCIAL AGREEMENT AND AUTHORIZATION FOR PAYMENT

I understand I am financially responsible, whether my insurance company pays or not, for all charges incurred by me. I further agree that in the event of nonpayment, I will bear the cost of collection and/or court costs and reasonable legal fees should such action be required. All accounts 90 days past due will incur a late fee of 10% per year. I agree that a photocopy of this authorization shall be as valid as the original.
I authorize payment of medical benefits to Creamer Physical Therapy, for services described on HCFA-1500 FORM.
I UNDERSTAND IF I FAIL TO GIVE A 24 HOUR NOTICE FOR A CANCELED APPOINTMENT, MY ACCOUNT WILL BE CHARGED $25.00 FOR A LATE CANCELLATION FEE.

X_____ **X**_____.
SIGNATURE DATE

Your doctor has prescribed physical therapy for you. Physical therapy is often an ongoing process which requires regular attendance to be effective. If you do not attend your scheduled sessions, you will be jeopardizing your progress.

Thank you for choosing Creamer Physical Therapy to assist in your health care.

PATIENT INFORMATION CONSENT FORM

I have read and fully understand Creamer Physical Therapy Notice of Information Practices. I understand that Creamer Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment of payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Creamer Physical Therapy will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Creamer Physical Therapy Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____

Patient Name

_____

Signature

_____

Date

Medicare

Lifetime Beneficiary Claim Authorization
("Signature On File")

_____ _____

(Name of Beneficiary) (Card Number, "HIC Number)

I request that payment of authorized Medicare-Benefits be made on my behalf to Creamer Physical Therapy, Inc. for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and any information needed to determine these benefits or the benefits payable for related services.

I understand my signature requests that payment authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA – 1500 claim form is completed, my signature authorizes releasing of the information and the insurer or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services.

Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

X_____ _____

Beneficiary Signature Date