Nosek & Associates Physical Therapy, Inc. / Nosek Physical Therapy, Inc.
26941 Cabot Road, Suite 125
Laguna Hills, CA 92653

PATIENT INFORMATION		
NAME (FIRST LAST)	DATE	EMAIL
STREET ADDRESS	HOME PHONE	CELL PHONE
CITY	STATE	ZIP
SSN	SEX M/F	
DATE OF BIRTH	AGE	DL #
REFERRING MD	PCP/DOCTOR	
DATE OF INJURY	CAUSE OF INJURY/DIAGNOSIS	
EMPLOYER NAME	OCCUPATION	
STREET ADDRESS	WORK PHONE	
CITY	STATE	ZIP

PRIMARY INSURANCE	SECONDARY INSURANCE
NAME OF INSURANCE	NAME OF INSURANCE
MAILING ADDRESS	MAILING ADDRESS
CITY	CITY
STATE ZIP	STATE ZIP
PHONE	PHONE
ID# GROUP#	ID# GROUP#

INSURED INFORMATION (RESPONSIBLE PARTY)	
NAME	NAME
SSN	SSN
DATE OF BIRTH	DATE OF BIRTH
STREET ADDRESS	STREET ADDRESS
CITY	CITY
STATE ZIP	STATE ZIP
EMPLOYER	EMPLOYER
RELATION TO PATIENT	RELATION TO PATIENT

Signature _____ Date _____

Nosek & Associates Physical Therapy, Inc. / Nosek Physical Therapy, Inc.
949) 273-6766 Fax (949) 273-6765

MEDICAL HISTORY AND PHYSICAL CONDITION

NAME: _____ DATE: _____

CHIEF COMPLAINT: _____

1. Do you now have or have you in the past, had any of the following conditions:

Allergies	yes ❑	no ❑	Heart Disease	yes ❑	no ❑
Autoimmune Disease	yes ❑	no ❑	Hernia	yes ❑	no ❑
Balance Problems	yes ❑	no ❑	High Blood Pressure	yes ❑	no ❑
Cancer	yes ❑	no ❑	HIV / AIDS	yes ❑	no ❑
Circulatory Problems	yes ❑	no ❑	Kidney Problems	yes ❑	no ❑
Diabetes	yes ❑	no ❑	Nervous Disorder	yes ❑	no ❑
Dizzy Spells	yes ❑	no ❑	Pregnancy	yes ❑	no ❑
Headaches	yes ❑	no ❑	Seizures	yes ❑	no ❑
Hearing Problems	yes ❑	no ❑	Sensitive to heat / cold	yes ❑	no ❑
Heart Attack	yes ❑	no ❑	Vision Problems	yes ❑	no ❑

If yes on any of the above, please explain and give approximate dates of occurrences:

_____

_____

_____

Please list any other conditions:

_____

_____

2. Have you had treatment for this / these problems before? Yes ❑ No ❑
If yes, where and when were you treated? _____

_____

3. Have you had surgery related to this / these problems? Yes ❑ No ❑
If yes, what type of surgery did you have and when was the surgery? _____

_____

4. Do you currently have any metal implants? Yes ❑ No ❑

5. Do you currently have a pacemaker? Yes ❑ No ❑

6. Do you have any communicable diseases? Yes ❑ No ❑

7. List any medications you are currently taking:

_____ _____

_____ _____

_____ _____

_____ _____

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Financial Policy and Patient Responsibility

It is the Patient's Responsibility:

- To know their insurance policy. Patients should be aware of their benefit coverage including which healthcare providers are contracted with their plan, covered and non-covered benefits, authorization requirements, and cost share information such as deductibles, coinsurance, and co-payments. If you are not familiar with your coverage, we recommend you contact your carrier directly.
- To obtain a referral from their Primary Care Physician (PCP) and/or obtain authorization for treatment from their insurance carrier *prior to receiving services*. Any non-covered services are the financial responsibility of the patient.
- To pay their co-payment/contribution towards deductible at the time of service.
- To pay any Medicare deductible and co-insurance amounts not covered by supplemental insurance.
- To promptly pay any patient responsibilities indicated by their insurance carrier and bring any insurance payment directly sent to the subscriber for third party endorsement to Nosek and Associates Physical Therapy / Nosek Physical Therapy.
- To facilitate claims payment by contacting their insurance carrier when claims have not been paid.
- To give 24 hour notice of any appointment cancellation. Failure to do so will result in a $25 charge for cancellations and /or "no-shows."
- To notify Nosek & Associates Physical Therapy / Nosek Physical Therapy prior to initiation of treatment if any condition is the result of an accident or work related injury.
- To know that Nosek & Associates Physical Therapy / Nosek Physical Therapy will not bill your private insurance if your injury is work/auto related or assigned to a lien case.
- To authorize the release of any pertinent information to my insurance company, adjustor, or attorney involved in my case.
- To know that all durable medical equipment and supplies purchased at Nosek & Associates Physical Therapy / Nosek Physical Therapy are non-returnable/non-refundable.

It is Nosek & Associates Physical Therapy's / Nosek Physical Therapy's responsibility:

- To provide quality medical care.
- To file insurance claims as a courtesy to patients. A 60 day period will be extended for pending insurance payment, after which the patient may be held responsible for the balance.

Financial Policy Acknowledgment:

I have read and understand the above financial policy. I understand that, regardless of my insurance claims status or absence of insurance coverage, I am ultimately responsible for the balance on my account for any services rendered. I understand that any payment which is delinquent (following 30 days from the request), may result in a 1.5% per month assessment on the remaining balance, and that I am fully responsible for any legal/collection or attorney's fees. There will be a total maximum fee of $50 charged to my account should it be sent to collections if it becomes necessary to resolve the outstanding balance. I understand that I will be charged a $25 fee for each returned check.

_____

Patient or Responsible Party Signature Date

Release of Medical Information and Assignment of benefits:

I authorize the release of medical information necessary for filing health insurance claims for me by Nosek & Associates Physical Therapy / Nosek Physical Therapy. I also authorize my insurance carrier(s) to make payment directly to Nosek & Associates Physical Therapy / Nosek Physical Therapy. I authorize Nosek & Associates Physical Therapy / Nosek Physical Therapy to release all information necessary to secure the payment of benefits, that a photocopy of this as valid as the original, and that my signature on this form constitutes assignment of benefits to Nosek & Associates Physical Therapy / Nosek Physical Therapy.

I consent to have Nosek & Associates Physical Therapy / Nosek Physical Therapy provide the treatment and care prescribed by my physician(s). I understand this consent may be revoked by me at any time.

_____

Patient or Responsible Party Signature Date