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 ____________________

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:

   ______________ ______________
   ______________ ______________
   ______________ ______________
   ______________ ______________

NOSEK & ASSOCIATES PHYSICAL THERAPY/NOSEK PHYSICAL THERAPY

26941 CABOT ROAD, SUITE 125/124
LAGUNA HILLS, CA 92653

FINANCIAL POLICY AGREEMENT AND PATIENT RESPONSIBILITY FORM

IT IS THE PATIENT'S RESPONSIBILITY:

- **TO KNOW THEIR INSURANCE POLICY. PATIENTS MUST BE AWARE OF THEIR BENEFIT COVERAGE INCLUDING WHICH HEALTHCARE PROVIDERS ARE CONTRACTED WITH THEIR PLAN, COVERED AND NON-COVERED BENEFITS, AUTHORIZATION REQUIREMENTS (INCLUDING PRE-AUTHORIZATIONS), PHYSICAL THERAPY VISIT LIMITATIONS AND COST SHARE INFORMATION SUCH AS DEDUCTIBLES, COINSURANCE, AND CO-PAYMENTS.**
- TO KNOW HIS/HER MEDICAL COVERAGE INCLUDING PROVISIONS SPECIFIC TO PHYSICAL THERAPY AND IS THE RESPONSIBILITY OF THE PATIENT TO CONTACT HIS/HER CARRIER DIRECTLY FOR DETAILS.
- **TO OBTAIN A REFERRAL FROM HIS/HER PRIMARY CARE PHYSICIAN (PCP) AND/OR OBTAIN AUTHORIZATION FOR TREATMENT FROM THEIR INSURANCE CARRIER *PRIOR TO RECEIVING SERVICES*. ANY NON-COVERED SERVICES/DENIED CLAIMS ARE THE FINANCIAL RESPONSIBILITY OF THE PATIENT.**
- TO KNOW IF HIS/HER INSURANCE BENEFIT POLICY ALLOWS PAYMENT OF PHYSICAL THERAPY CLAIMS VIA DIRECT ACCESS/NO REFERRAL BY PHYSICIAN.
- TO PAY HIS/HER DEDUCTIBLE, CO-PAYMENT OR CO-INSURANCE CONTRIBUTION AT THE TIME OF SERVICE.
- TO PAY ANY MEDICARE DEDUCTIBLE AND CO-INSURANCE AMOUNTS NOT COVERED BY SUPPLEMENTAL INSURANCE. BE AWARE THAT SUPPLEMENTAL INSURANCES MAY CARRY A DEDUCTIBLE RESPONSIBILITY.
- TO PROMPTLY PAY ANY PATIENT RESPONSIBILITY INDICATED BY THEIR INSURANCE CARRIER AND BRING ANY INSURANCE PAYMENTS DIRECTLY SENT TO THE SUBSCRIBER FOR THIRD PARTY ENDORSEMENT TO NOSEK AND ASSOCIATES PHYSICAL THERAPY/NOSEK PHYSICAL THERAPY.
- TO FACILITATE ANY CLAIMS PAYMENT BY CONTACTING THEIR INSURANCE CARRIER WHEN CLAIMS HAVE NOT BEEN PAID/DENIED/DEEMED NOT MEDICALLY NECESSARY. PATIENTS ARE HELD RESPONSIBLE FOR PAYMENT OF DENIED CLAIMS AND/OR CLAIMS DENIED AS NOT MEDICALLY NECESSARY.
- **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 AUTHORIZE THE RELEASE OF ANY PERTINENT INFORMATION TO HIS/HER INSURANCE COMPANY, ADJUSTOR, OR ATTORNEY INVOLVED IN HIS/HER CASE.
- TO KNOW THAT ALL DURABLE MEDICAL EQUIPMENT AND SUPPLIES PURCHASED AT NOSEK & ASSOCIATES PHYSICAL THERAPY ARE NON-RETURNABLE AND CLASSIFIED AS "FINAL SALE."
- ***TO GIVE 24-HOUR NOTICE OF ANY APPOINTMENT CANCELLATION. FAILURE TO DO SO WILL RESULT IN A $50 CHARGE FOR CANCELLATIONS AND /OR "NO-SHOWS."***

MASSAGE THERAPY SERVICES CLIENT RESPONSIBILITY:

- TO KNOW THAT ANY MASSAGE THERAPY SERVICES ARE NOT BILLABLE TO THE PATIENT'S INSURANCE COMPANY.
- TO KNOW THAT MASSAGE THERAPY PACKAGES/CERTIFICATES PURCHASED ARE NON-REFUNDABLE YET ARE TRANSFERABLE TO ANOTHER PERSON UPON THE WRITTEN REQUEST OF THE MASSAGE CLIENT WHO PAID FOR THE CERTIFICATE.
- TO KNOW THAT MASSAGE THERAPY APPOINTMENTS ARE SUBJECT TO A 24- HOUR CANCELLATION POLICY. FAILURE TO GIVE 24-HR NOTICE OF MASSAGE APPOINTMENT CANCELLATION OR "NO-SHOWS" WILL RESULT IN A $50 CANCELLATION FEE.

NOSEK & ASSOCIATES PHYSICAL THERAPY/NOSEK PHYSICAL THERAPY

PHONE: 949-273-6766 FAX. 949-273-6765

NOSEK & ASSOCIATES PHYSICAL THERAPY/NOSEK PHYSICAL THERAPY

26941 CABOT ROAD, SUITE 125/124
LAGUNA HILLS, CA 92653

IT IS NOSEK & ASSOCIATES PHYSICAL THERAPY/NOSEK PHYSICAL THERAPY RESPONSIBILITY:

- TO PROVIDE QUALITY MEDICAL CARE WITHIN THE SCOPE OF PHYSICAL THERAPY SERVICES.
- TO FILE INSURANCE CLAIMS AS A COURTESY TO PATIENTS. A 60-DAY PERIOD WILL BE EXTENDED FOR PENDING INSURANCE PAYMENT, AFTER WHICH TIME THE PATIENT MAY BE HELD RESPONSIBLE FOR THE ACCOUNT BALANCE FOR CARE PROVIDED INCLUDING ACCRUED LATE FEES.
- TO MAKE EFFORTS TO PROVIDE A COURTESY BENEFIT/ELIGIBILITY CHECK FROM THE PATIENT'S INSURANCE COMPANY FOR THE PURPOSES OF OBTAINING AN ESTIMATE OF THE PATIENT'S FINANCIAL RESPONSIBILITY. ANY INFORMATION QUOTED BY THE INSURANCE COMPANY (VIA A CUSTOMER SERVICE REPRESENTATIVE OR ONLINE PROVIDER PORTAL) TO NOSEK & ASSOCIATES PHYSICAL THERAPY/NOSEK PHYSICAL THERAPY IS NOT A GUARANTEE OF CLAIMS PAYMENT BY THE INSURANCE COMPANY FOR SERVICES RENDERED AND IS ULTIMATELY THE FINANCIAL RESPONSIBILITY OF THE PATIENT.
- TO FURNISH A COPY OF PATIENT MEDICAL RECORDS IF REQUESTED BY THE PATIENT. WRITTEN CONSENT WILL BE SIGNED BY THE PATIENT ACKNOWLEDGING THE REQUEST FOR RECORDS RELEASE. A COPY FEE OF $0.25/PAGE WILL BE ASSESSED PLUS A CLERICAL FEE OF $25 TO BE PAID BY THE PATIENT PRIOR TO THE RELEASE OF RECORDS. IN ADDITION, PATIENT REQUESTS TO MAIL RECORDS WILL HAVE ADDITIONAL POSTAGE FEES ADDED TO THE TOTAL CHARGE OF THE COPY SERVICE.

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 $75 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 $30 FEE FOR EACH RETURNED CHECK.

PATIENT NAME PRINTED PATIENT/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 IS 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 THIS HEALTHCARE PROVIDER PROVIDE THE TREATMENT AND CARE PRESCRIBED BY MY PHYSICIAN(S) OR BY PATIENT CONSENT VIA DIRECT ACCESS. I UNDERSTAND THIS CONSENT MAY BE REVOKED BY ME AT ANY TIME.

PATIENT NAME PRINTED PATIENT/RESPONSIBLE PARTY SIGNATURE DATE