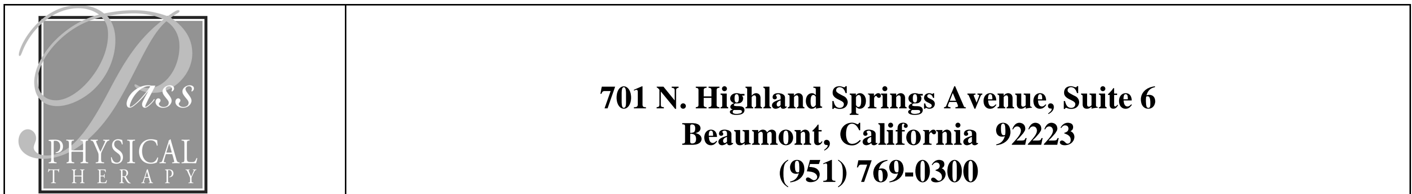

701 N. Highland Springs Avenue, Suite 6
Beaumont, California 92223
(951) 769-0300

Last Name:	First Name:	M.I.
Address:	City:	ZIP:
Social Sec#:	PH#:	Sex: M❑ F❑

Marital Status: M❑ S❑ D❑	DOB:	Height:	Weight:
Emergency Contact:			PH#:

Employer Name:		PH#
Address:	City:	ZIP:

Medical Conditions

Diabetes ❑ Pacemaker ❑ Seizures ❑	Severe Headaches ❑ High Blood Pressure ❑ Nervous Disorder ❑	Metal Implants ❑ Heart Disease ❑ Pregnant ❑	Other ❑ Cancer ❑

Explain Above Conditions:

List Medications Related to Treatment:

Reason For Physical Therapy:	Date Of Injury:
How Were You Injured?	
Have You Had Previous Treatments For Your Present Condition? Yes ❑ No ❑ If Yes, When? Where?	
Are You Currently Working? Yes❑ No❑	Occupation

Release of Information

- All information herein and on next page is true and correct. I hereby consent to treatment
- I give permission to Adorador Enterprises Inc. DBA Pass Physical Therapy to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment
- I authorize Adorador Enterprises Inc. DBA Pass Physical Therapy to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.
- Information without patient identifiers may be used for quality assurance purposes.
- I have read and understand the above release.

Patient or Guardian Signature:	**Date:**

Assignment of Benefits & Payment Guarantee

- I authorize payment of benefits directly to Pass Physical Therapy. This is a direct assignment of my rights and benefits under this policy.
- I agree to pay Adorador Enterprises Inc. DBA Pass Physical Therapy for the services provided to me or the party named above. If any law, such as workers compensation, or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.
- If the information provided by my insurance company is not accurate or the insurance company changes coverage, I will be responsible for payment for services.
- I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of Adorador Enterprises Inc. DBA Pass Physical Therapy.
- A photocopy of this assignment shall be considered as effective and valid as the original.

Patient or Guardian Signature:	**Date:**

Notice of Privacy Practices (HIPAA Acknowledgement/Consent)

- I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Pass Physical Therapy
- In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operations.

Patient or Guardian Signature:	**Date:**

Medicare Disclosure Form

Name of Beneficiary:	**HIC Number:**

- I request that payment of authorized Medicare Benefits be made either to me or on my behalf to (Pass Physical Therapy) for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.
- I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes the release of the information to the insurer or agency shown. In Medicare assigned cases, the physician 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.

Beneficiary Signature:	**Date:**