

PATIENT INSURANCE AUTHORIZATION WORKSHEET

We accept all insurances that have **in-network and out-of-network** benefits. If you do not have insurance benefits for physical therapy, please call us at 858-457-3545 to discuss our payment plans. We also have payment plans for patients with high deductibles.

To obtain your insurance authorization for physical therapy call the Member Services toll free number on your insurance card. Make sure you speak to a human being, do not use the automated system.

Please have the following on hand for your call:

- a. **Your insurance card**
- b. **Kate Grace PT's TIN (tax id no.) 33-0127638**
- c. **Kate Grace PT's NPI (national provider identification) 1740201730**

During your phone call to your insurance's Member Services department be sure to get and record the following:

Date _____

Name of the person you are speaking with _____ Time of day _____

What is the reference # for this call? (i.e. Tracking ID for the call or the representative ID) _____

Here is the TIN for my provider 33-0127638, do I have in-network or out-of-network benefits? _____

How much is my deductible for Physical Therapy? _____

How much of my deductible has been met? _____

What is my co-pay percentage (30%, 20%, 10%) or dollar amount per visit? _____

Does my policy require pre-certification or pre-authorization for physical therapy services? Y/N _____

Is there a maximum \$ cap that my plan pays for physical therapy? If so, how much? _____

What are the calendar limits, if any for physical therapy? _____

Are there any per visit limitations for physical therapy? _____

Are there any per diagnosis limitations for physical therapy? _____

What is the claims address for my insurance? _____

I understand that I am responsible for obtaining accurate information about my insurance benefits for physical therapy so that Kate Grace Physical Therapy can bill my insurance company correctly and efficiently on my behalf. If the above information is inaccurate, I will be responsible for paying the balance for my visits to Kate Grace Physical Therapy and working directly with my insurance company to resolve any differences in what was quoted to me versus what was paid for my physical therapy services.

If you have any questions or need help obtaining this insurance authorization and benefits information from your insurance carrier please contact us at 858-457-3545.

Patient Signature: _____



Authorization to Release Information

I hereby authorize *Kate Grace Physical Therapy* to release any information acquired in the course of my evaluation or treatment for billing purposes.

Signed by the subscriber

I hereby authorize *Kate Grace Physical Therapy* to release any information regarding my medical condition to the attending or referring medical practitioner.

Signed by the subscriber

Authorization to Pay Benefits

I direct that payments be made directly to Kate Grace Physical Therapy. I understand that I am financially responsible for all charges not paid by my insurance. I also understand that all payments made directly to me are to be forwarded to this offices.

Signed by subscriber

Please Print Name _____



Dear Patient,

Your insurance may pay your total bill for services rendered at ***Kate Grace Physical Therapy***. However, it is likely that your insurance will pay some portion of the charge(s). The unpaid portion of the bill is your responsibility. Please contact your insurance carrier directly if you feel your insurance company has underpaid its portion. Please remember that you are responsible for your deductible and co-payment. You will receive a monthly statement indicating the status of your account with ***Kate Grace Physical Therapy***.

Cash Pay Patients: Even though you may have health insurance benefits that would pay all or some portion of your physical therapy charges, you may choose to pay cash for services rendered at Kate Grace Physical Therapy.

If at any time during the period you are a patient at Kate Grace Physical Therapy you decide to stop paying cash and start using your insurance benefits you have one of two options:

Option 1: Your insurance will be billed from the date of service you decide to start using your insurance moving forward. Any prior visits paid for using cash **will not** be billed retroactively.

Option 2: If you want your insurance to be billed retroactive to your first date of service, you will pay \$10 for each date of service in the past to cover the administrative costs of retroactive billing.

We believe that you are entitled to the benefits of your insurance plan and we believe the services provided to you by Kate Grace Physical Therapy are within these benefits. You, as a plan member, are always more successful at dealing with your insurance company directly. Please make an effort to defend your rights as a member in your plan. You deserve the best care possible and you certainly have the right to demand excellent care.

If there is anything we can do to assist you, please do not hesitate to ask for help. Thank you for your cooperation in this matter.

Warm regards,

Kate Grace Physical Therapy



8929 University Center Lane • Suite 200 • San Diego, CA • 92122
P 858-457-3545 • F 858-457-0976
www.kgpt.com

Waiver in Connection with use by Members and Guests of Kate Grace Physical Therapy

The execution of this form is a condition to use by member and guests of Kate Grace Physical Therapy. This form is intended to affect your right to maintain certain claims and legal actions against Kate Grace Physical Therapy weight/exercise room in the event of illness or injury and should be read carefully.

As a condition to my use of the Kate Grace Physical Therapy weight/exercise room, I agree to indicate in the space provided below any health problems or physical impairments which would affect my ability to participate in exercise programs or otherwise engage in exercises at Kate Grace Physical Therapy.

I hereby release Kate Grace Physical Therapy (the owners of the facility), its agents, directors and employees and its and their successors and assigns from any and all claims and demands of whatever nature for any and all losses, expenses, damages and costs suffered or incurred by an account of, or in any way growing out of illness or injuries which I may suffer or sustain by virtue of my use of the Kate Grace Physical Therapy weight/exercise room except for illness or injury suffered or sustained by me as a direct result of the gross negligence or willful misconduct of Kate Grace Physical Therapy or its owners, guests, directors and employees. No employee nor agent of Kate Grace Physical Therapy has the authority to alter in any way the provisions stated herein.

I have read the foregoing and understand it and any questions I may have asked regarding the use of the Kate Grace Physical Therapy weight/exercise room have been answered to my satisfaction.

Name Printed

Member/Guest Signature

Date

Statement of Member/Guest as to physical impairment(s)

Does the member/guest have any physical impairment(s) or illness which could affect his/her participation in an exercise program(s) at Kate Grace Physical Therapy?

Yes _____ No _____

If yes, please explain _____





NOTICE OF PATIENT INFORMATION PRACTICES

****THIS NOTICE DESCRIBES HOW YOUR PERSONAL MEDICAL INFORMATION MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW CAREFULLY.****

KATE GRACE PHYSICAL THERAPY'S LEGAL DUTY

Kate Grace Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Kate Grace Physical Therapy uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide. For example, **Kate Grace Physical Therapy** may use your personal health information to contact you to provide appointment reminders, information about treatment alternatives, or other health related benefits that could be of interest to you.

Kate Grace Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies, or for emergencies. We also provide information when required by law.

In any other situation, **Kate Grace Physical Therapy's** policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Kate Grace Physical Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request a copy of our Notice Of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we are not to use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. **Kate Grace Physical Therapy** will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that **Kate Grace Physical Therapy** may have violated your privacy right or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed above. You may also send a written complaint to the US Department of Health and Human Services.



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PATIENT INFORMATION CONSENT FORM

I have read and fully understand Kate Grace Physical Therapy’s “Notice of Information Practices.” I understand that Kate Grace 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 or 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 Kate Grace 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 the Kate Grace Physical Therapy’s “Notice of Information Practices.” I understand that I retain my right to revoke this consent by notifying the practice in writing at any time.

Patient Name

Signature

Date



PATIENT RIGHTS

The following is our policy regarding the rights of the patients receiving service from ***Kate Grace Physical Therapy***. Each patient has the right to:

- A. Be fully informed of his/her rights as well as all rules and regulations of ***Kate Grace Physical Therapy*** governing patient expectations.
- B. Be fully informed at the time of admission of services available and related charges not covered under Title XVIII of the Social Security Act.
- C. Be fully informed by a physician of his/her medical condition unless medically contraindicated, and to be afforded the opportunity to participate in the planning of his/her medical treatment.
- D. Refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.
- E. Be assured confidential treatment of clinical records and to approve or refuse their release to any individuals, except in the case of transfer to another health care facility, or as required by law or third party payment contracts.
- F. Be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and care of personal needs.
- G. Be informed by ***Kate Grace Physical Therapy*** of the provision of the law regarding complaints and of procedures for registering complaints confidentially including, but not limited to the address and telephone number of the complaint receiving unit of the California Department of Health Services.
- H. Be assured that personnel who provide care are qualified through education and experience to carry out the services for which they are responsible.
- I. Be informed that these rights may be denied for good cause only by the attending Physical Therapist. Denial of such rights shall be documented by the attending Physical Therapist in the patient's clinical record.

Any complaints regarding denial of patients rights not satisfied after a discussion with **Kate Grace Physical Therapy** may be registered in confidence with the California Department of Health Services. Upon request, the staff of **Kate Grace Physical Therapy** will assist the patient to contact the appropriate office of the state agency.



Patient Intake Questionnaire

Date: _____

Patient's Name: _____

Age: _____ Sex: _____

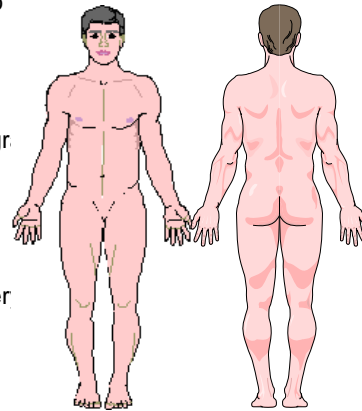
Kate Grace Physical Therapy
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About your current complaint:

1. What is the complaint that brought you here? _____
2. When did this complaint begin, or recently become worse? Approximate Date: _____
3. What caused this complaint? _____
4. Does this complaint affect your activity choice, tolerance, efficiency or effectiveness: Yes No
 If "Yes", what activities? _____

5. What makes this complaint better? _____
6. Does this complaint affect your comfort, mood, or ability to sleep? Yes No

7. What symptoms are you experiencing with this complaint?
 Swelling Loss of balance or coordination
 Loss of motion Numbness Pain: Draw pain areas on body diag.
 Weakness Tingling Other (Specify) _____



8. How frequent are the symptoms experienced? Constant Intermittent
9. How much pain are you experiencing?
 None Very Mild Mild Moderate Severe Ver

10. What tests have you had for this complaint?
 X-ray CT Scan MRI Myelogram Bone Scan
11. What treatment have you had for this complaint? Physical Therapy Occupational Therapy
 Athletic Training Chiropractic Alternative Medicine-(Specify): _____

12. Is this complaint work related? Yes No
 If "Yes", your employer's name: _____ Your Occupation: _____
 Work Status: Full Time Part Time Working Medical Restrictions Medical Leave Last Date Worked: _____

13. Is this complaint auto related? Yes No

About your general health:

14. Please check all medical conditions that you have, or have had.
 Arthritis Heart Disease Stomach Disorder Headaches Pace Maker
 Cancer High Blood Pressure Anxiety Dizziness Other: _____
 Diabetes Lung Disease Depression Metal Implants
 Stroke/Seizure Thyroid Problems Panic Attacks Morning Stiffness

15. Please check all of the following items that currently apply to you.
 Hearing Problem Visual Problems Learning Problems
 Pregnant Bowel or bladder control Smoker Recent weight loss

16. Please list surgeries: _____

17. Please list allergies: _____

18. Please list medications you are currently taking: _____

19. What goals do you want to achieve through your treatment at Kate Grace Physical Therapy? _____

Please use the back of page for additional writing space as needed.

COMPLIMENTARY 30 MINUTE THERAPUTIC MASSAGE

Do you have friends, family members, or co-workers who have aches and pains?

Do you know someone who would like to increase their athletic performance?

Do you know someone who would like to start a fitness program?

We want to HELP!

Refer them to Kate **Grace Physical Therapy**.

To express our appreciation for your referral, you will receive a

Complimentary 30 Minute Massage

from one of our highly trained Massage Therapists.

Please contact us at 858-457-3545 to arrange a time for your massage or simply stop at the Front Desk during one of your visits to our clinic.

Please complete the following information for our records:

Your Name: _____ Phone: _____

Patient Referred: _____ Phone: _____



PATIENT ACCEPTANCE OF FINANCIAL RESPONSIBILITY

The practice of *Kate Grace Physical Therapy* will bill your insurance company as a courtesy. However, **you are ultimately responsible for ALL** charges for services rendered. In the event services rendered are not covered by your insurance company, we will require that you remit payment to *Kate Grace Physical Therapy*. Additionally, if your insurance company does not remit payment in a timely manner (within 60 days from the time your claim is billed), we will transfer the balance to your responsibility and require that you remit payment to *Kate Grace Physical Therapy* for all outstanding insurance balances over 60 days. The outstanding balances may include, but are not limited to:

- Office visit co-payments
- Annual deductibles
- Services that are not covered by your health plan
- Administrative charges for co-pays not paid at the time of service
- Interest charges for overdue patient due balances

In addition, your insurance company may require an authorization or pre-certification for certain procedures, services, and supplies that will be provided to you. As a courtesy, we will contact your insurance company for authorization for services. However, it is ultimately your responsibility to understand what your insurance policy covers and assure that you have authorization for services. We may request your assistance in following up on our authorization requests and delayed payments. Your assistance in contacting your insurance company will often facilitate a more timely approval of services, prevent delays in treatment, and expedite payment for your services.

We require timely payment when you receive your monthly statements. Balances are due upon receipt of your statement. You will be charged a “No Show” charge of \$60.00 for all appointments that you miss and fail to give at least 24 hours notice. If you need to cancel an appointment, please make a note of who you spoke to when you called to cancel your appointment, the date and time.

Your co-payment is required at the time you check-in for your appointment. If you fail to bring your co-payment and we must bill you for it, an administrative charge of \$15 will be added to your bill.

I understand and agree that I (or the person named below who is financially responsible for me) am financially liable for all services rendered and will pay my outstanding balance within 10 days of receipt of my monthly statements. I also understand that if my insurance plan does not pay *Kate Grace Physical Therapy* within 60 days of services billed, the balance will be transferred to my responsibility and payment will be due at that time.

Patient Printed Name

Responsible Party’s Printed Name

Patient’s Signature Date

Responsible Party’s Signature Date

