MEDICARE "SIGNATURE ON FILE" REQUIREMENTS

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Seven Oaks Rehabilitation and Fitness Center 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 of the benefits payable to related services.

I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 form is completed, my signature authorizes releasing of the information to the insurer or the agency shown. In Medicare assigned cases, the physician/supplier agrees to accept the charge determination of the Medicare carrier as the full charge. 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.

____

Signature of Beneficiary Date

ADVANCE BENEFICIARY NOTICE REGARDING MEDICARE

By my signature I acknowledge that I have not recently received any care from a Home Health Agency (nursing, social worker, physical therapy) or if I have, that I have been discharged from their care. Additionally, should I require Home Health Care services during the course of my treatment here, I will advise 7 Oaks. Medicare does not cover/pay for out patient physical therapy if you are receiving any type of Home Health Services.

____

Signature of Beneficiary Date

PATIENT INFORMATION SHEET ACCT # PT

Patient name: ____
LAST FIRST MIDDLE

Date of Birth: __________ Age: ____________________ (please circle :) Female Male

Address: ______________________________ **Responsible Party SS#:**__________
Required If patient a minor and/or full-time student

City: ______________________ State: ______ Zip: ______________

Home Phone # ________________________ Work/ Cell Phone # ________________________

Patient SS# ________________________ Drivers License #________________________

Employer:________________________ Occupation: ________________________

Employer's City: ________________________ State: __________ Zip: ______________

Marital Status (please circle): Married Single Divorced Widowed

Name of Spouse: ________________________ Spouse's Work Phone # ________________________

Primary Insurance Company: ________________________ Name of Insured:________________________

Relationship to Insured: ________________________ Insured's DOB: ________________________

Insured SS # ____________ Group Name/Number: ______________ Policy #______________

Secondary Ins: ________________________ **Name of Insured:** ________________________
SEVEN OAKS WILL ONLY BILL 2ND IF WE ARE CONTRACTED PROVIDER

SS# / Policy # of insured: ________________________ Insured's DOB: ________________________

Referring Physician: ________________________ Phone #: ______________ Fax #: ______________

Date of Injury/Start of Symptoms: __________ **Area of Body to be treated** ________________________
INSURANCE REQUIRES THE DATE, MONTH AND YEAR (WILL NOT PAY WITHOUT THIS INFORMATION)

Type of Accident/Illness: ________________________ No ____ Yes ________________________
(Home? Work? Sports? Auto?) Do you have an **Atty? If so, Name & Tel number**

I DO HEREBY ASSIGN all insurance benefits to be paid directly to S**even Oaks Rehabilitation & Fitness Center** for all medical services provided to me. I also acknowledge that I am personally liable for all charges incurred by me for treatment services provided me by **Seven Oaks Rehabilitation & Fitness Center. I further authorize Seven Oaks Rehabilitation & Fitness Center** to release information required regarding the course of my treaunent, for the purpose of evaluating and administering claims for benefits. I understand I am responsible for services not cover by my insurance, i.e. benefits exhausted or do not meet criteria of medical necessity per your pJan's guidelines. **I have been informed of & agree to abide by the cancellation policy. ANY PERSONAL BALANCE 30 DAYS OR MORE PAST DUE MAY BE SUBJECT TO A 1.5% FINANCE CHARGE.**

____ ______________
SIGNATURE OF PATIENT / PARENT IF MINOR DATE

____ ______________
SIGNATURE OF RESPONSIBLE PARTY / PARENT IF PATIENT IS FT STUDENT DATE

Seven Oaks Patient Medical History Forms

Patient Name: ____ Date: ________________________________

Date of Birth: ________/________/__________ Age: ____________ Date of Injury/Onset: __________________________

Referring Physician: ___________________________________ Family Physician: ____________________________________

Height: _____________ Weight: ______________ Patient Appointment Reminder Phone #: ___________________________

THE FOLLOWING FIVE QUESTIONS MUST BE ANSWERED

1.) For What Condition or Symptoms are You Being Seen for at This Time?

2.) When Did This Condition Begin?

3.) What Treatment Have You Already Received?

4.) Has This Problem Occurred in the Past?

5.) Have You Had Two or More Falls in the Past Year, and/or Any Fall Resulting in Injury in the Past 12 Months? YES NO

MEDICATION

Please List All Present Medications. Please Also Note Dosage/Frequency of Use.

Name of Medication	Dosage/Frequency of Use
1	
2	
3	
4	
5	
6	

PAST MEDICAL HISTORY

Please Check YES or NO Whether You Have Had the Following Conditions

Condition			Condition		
Heart Disease/Heart Attack	Yes	No	Peptic Ulcer/Pancreatitis	Yes	No
Rheumatic Fever	Yes	No	Anemia/Blood Disorders	Yes	No
High Blood Pressure	Yes	No	Bleeding Disorder	Yes	No
Stroke	Yes	No	Jaundice	Yes	No
Epilepsy or Convulsions	Yes	No	Hernia	Yes	No
Kidney or Bladder Problems	Yes	No	Thyroid Disorders	Yes	No
Diabetes	Yes	No	Venereal Disease	Yes	No
Tumor or Cancer	Yes	No	Genital/Gynecologic Disorders	Yes	No
Pneumonia or Emphysema	Yes	No	Congenital Abnormalities	Yes	No
Respiratory Disease	Yes	No	Are You Now Pregnant?	Yes	No
Tuberculosis	Yes	No	Do You Have a Pacemaker?	Yes	No
Asthma	Yes	No	Do You Have Surgical Implants?	Yes	No

Any Other Conditions Not Listed Above?

SURGERY
Please List All Previous Surgeries & Indicate the Date/Approximate Age at Time of Procedure:

Surgery/Procedure	Date/Approximate Age

FRACTURES AND OTHER SERIOUS INJURIES Please List the Type and Date

Fracture/Injury	Date

ALLERGIES **Please List All Allergies**

Penicillin or Other Antibiotic: ______
Morphine, Codeine or Other Narcotic: ______
Novacain or Local Anesthetic: ______
Iodine Compounds: ______
Others Not Listed: ______

FAMILY HISTORY
Please Check Yes or No to the Following

Heart Disease	Yes	No	Bleeding Tendency	Yes	No
Cancer	Yes	No	Diabetes	Yes	No
Arthritis	Yes	No	Stroke	Yes	No
High Blood	Yes	No	Pressure	Yes	No
Gout	Yes	No			

Please provide us with all information concerning your insurance coverage at the time of your first visit to our office.

We wish to stress that the financial responsibility for services rendered rests with the patient or their family, regardless of any insurance coverage. Remember that very few insurance policies pay 100% of the bill submitted. We strongly recommend each patient/guardian/primary cardholder call your insurance company and review your individual policy concerning physical therapy coverage.

______ ______
Patient Signature/Responsible Party Date

Seven Oaks Cancellation Policy

Cancellation Policy Effective November 1, 2009
RE: Missed (No Show) and Late Notice

REASONABLE NOTICE (SEE BELOW) IS REQUIRED OR A **$50.00 FEE** WILL BE ADDED TO YOUR ACCOUNT FOR EACH MISSED APPOINTMENT. YOUR THERAPIST HAS THIS TIME RESERVED TO TREAT YOU AND IF YOU DO NOT SHOW, THIS TIME IS WASTED.

MOST MEDICAL OFFICES REQUIRE A 24-HOUR CANCELLATION NOTICE TO AVOID A CANCELLATION CHARGE. SEVEN OAKS HAS SIGNIFICANTLY REDUCED THIS PERIOD IN ORDER TO ACCOMMODATE UNFORSEEN EVENTS AND TO MAKE IT LESS LIKELY YOU WILL BE ASSESSED A CANCELLATION FEE, BUT STILL PROVIDE SEVEN OAKS TIME TO FILL A CANCELLED TIME WITH ANOTHER PATIENT WHO MAY BE WAITING FOR AN APPOINTMENT.

REASONABLE NOTICE FOR A MORNING APPOINTMENT IS ANYTIME PRIOR TO 6:00 PM THE EVENING BEFORE. REASONABLE NOTICE FOR AN AFTERNOON APPOINTMENT IS NOT LESS THAN 6 HOURS PRIOR TO YOUR APPOINTMENT TIME.

WE APPRECIATE YOUR COOPERATION & UNDERSTANDING.
THANK YOU.

____
patient initials
acknowledgement

Explanation of Insurance Benefits

Here at Seven Oaks we attempt to call each of our patient's insurance company to determine the physical therapy benefits and to advise each patient of their benefits at this facility as a courtesy. Due to the amount of patients we see at our facility and the time it takes to directly contact an insurance company rep, we cannot give an immediate response regarding insurance benefits, which is why we highly encourage each patient to call their insurance. It is ultimately the patient's responsibility to understand your insurance company's eligibility and benefits. This includes in-network/out-of-network benefits for our facility, deductibles, co-pays, number of visits allowed, treatments allowed, authorization required, etc. If you desire, please request our "Patient Verification Form" that contains pertinent information you should obtain when contacting your insurance company. Please understand that the information that is provided to us regarding your insurance is not a guarantee of payment, but simply what is told to us over the phone at the time of the call. Also note that Seven Oaks will only bill a secondary insurance if we are a contracted provider.

If your insurance plan benefits are not what you think they are, it could result in significant out of pocket expenses that you did not expect. Do not hold Seven Oaks responsible for what your insurance company may or may not pay. The type of insurance benefits you have are between you, the policy holder, and your insurance company. If you have a large deductible that has not been met or if you have a co-pay for each visit, you will need to pay for services at the time of each visit. We strongly encourage each patient to call/review their insurance for an explanation of benefits if you have not already done so.

Following your conversation with your insurance company, should you have any additional questions about your insurance benefits, please contact our business office and we will try to explain what we can. However, remember we cannot and do not have any way to guarantee what your insurance plan may or may not pay.

For our **MEDICARE PATIENTS**, if your Medicare Part B insurance coverage is current, not assigned to a HMO, or a Home Health Service, it is not necessary for you to call Medicare for insurance information. All Medicare benefits are standardized and *Seven Oaks Physical Therapy & Fitness Center* is a Medicare certified facility. We do highly suggest Medicare patients call to verify benefits with their secondary insurance since there are many different plans and some may not be 'supplemental' to Medicare.

Seven Oaks appreciates your business and part of our practice courtesy is to let all patients know upfront that it is necessary to contact your insurance company to avoid any unexpected results.

Thank You.

I understand that it is my responsibility to call and determine what my insurance plan benefits are for physical therapy at *Seven Oaks Physical Therapy & Fitness Center, Inc.*

____ ______________________

Signature of Patient or Financially Responsible Person Date

Seven Oaks Notice of Patient Information Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU
MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION.
PLEASE REVIEW IT CAREFULLY.

SEVEN OAKS PHYSICAL THERAPY & FITNESS CENTER, INC'S LEGAL DUTY

Seven Oaks Physical Therapy & Fitness Center, Inc. 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

Seven Oaks Physical Therapy & Fitness Center, Inc. use 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, Seven Oaks Physical Therapy & Fitness Center, Inc. may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Seven Oaks Physical Therapy & Fitness Center, Inc. may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Seven Oaks Physical Therapy & Fitness Center, Inc.'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.

Seven Oaks Physical Therapy & Fitness Center, Inc. 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 an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to obtain a copy of your personal health information. Seven Oaks Physical Therapy & Fitness Center, Inc. shall have not less than 48 hours from the date of your written request to prepare and copy your medical records. The fee for copying is $30.00. 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 not 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. Seven Oaks Physical Therapy & Fitness Center, Inc. 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 Seven Oaks Physical Therapy & Fitness Center, Inc. may have violated your privacy rights of 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 below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Seven Oaks Physical Therapy & Fitness Center, Inc.'s health information practices or if you have a complaint, please contact the following person:

Seven Oaks Physical Therapy & Fitness Center, Inc.
ATTN: OFFICE MANAGER
141 Triunfo Canyon Road

Westlake Village, CA 91361
Telephone: (805) 373-6560 Fax: (805) 373-5120

PATIENT INFORMATION CONSENT FORM

In the event we need medical information from your Physician in the course of your treatment, please sign the medical information release below:

My signature authorizes my referring Doctor to provide Seven Oaks Physical Therapy & Fitness Center, Inc. with my personal medical information in order that my Physical Therapist may provide more appropriate treatment.

____
Printed Patient Name

____ ________________________
Signature Date

SEVEN OAKS PHYSICAL THERAPY & FITNESS CENTER, INC.
PATIENT INFORMATION CONSENT FORM

I have read and full understand Seven Oaks Physical Therapy & Fitness Center, Inc.'s Notice of Information Practices. I understand that Seven Oaks Physical Therapy & Fitness Center, Inc. may use or disclose my personal health information for 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 for treatment, payment and administrative operations if I notify the practice. I also understand that Seven Oaks Physical Therapy & Fitness Center, Inc. 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 Seven Oaks Physical Therapy & Fitness Center, Inc.'s Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

____
Printed Patient Name

____________________________________ ________________________
Signature Date

INFORMED CONSENT FOR PHYSICAL THERAPY TREATMENT

Welcome to Seven Oaks Physical Therapy and Fitness Center. This form is an effort by Seven Oaks to provide you with information about your physical therapy treatment here at Seven Oaks that is administered by the physical therapist, physical therapy assistant or other ancillary personnel. The purpose of "informed consent" is to provide you with sufficient information so that you can make an "informed" decision regarding your consent to physical therapy treatment. It is our desire and goal to provide you with appropriate and safe treatment that will result in an improvement in your particular condition. However, because there are many factors and issues involved in a specific individual's medical condition and treatment we are unable to guarantee that every individual medical condition will respond positively to treatment.

Physical therapy involves many types of treatments, procedures and modalities. The type of treatment the therapist incorporates into your treatment care plan is generally based on the information gleaned from the prescription of your referring physician, your initial evaluation, and your response to various types of procedures employed during your treatment. Your treatment may be altered or changed by the therapist based on your response to current treatment and as your condition changes. As you may be aware there are benefits and risks associated with all types of medical treatment and this includes physical therapy treatment. While it may be possible to make an extended and long list of potential risks from all types of physical therapy treatment it is not practical nor is it likely to result in providing you with information that allows you a better understanding of "risks vs. benefits". We encourage you to ask your therapist about any concerns or questions you may have regarding your treatment. He or she will be glad to discuss and review any particular treatment that you are receiving.

Manual therapy (includes joint mobilization, soft tissue mobilization, and manual traction) and therapeutic exercise are frequent procedures utilized at Seven Oaks that we believe provide our patients with significant benefits. Manual therapy involves applying varying degrees of pressure with the therapist's hands on the treatment area or surrounding area of your body. Manual therapy and exercise have inherent physical risks associated with them. These risks may include, but are not limited to, muscle and soft tissue strains or soreness, joint strains and sprains, intravertebral disc injury, heart attacks or cardio-vascular complications, bone injuries, strokes, and other complications known and unknown at this time.

By signing this form you are consenting to treatment by Seven Oaks Physical Therapy and Fitness Center, Inc. You are acknowledging that you understand and are accepting the benefits and risks of physical therapy treatment. You understand that you may question your physical therapist at any time regarding your treatment and that you may decline any proposed treatment or stop any treatment at any time that is currently being utilized.

Patient Signature ______________________ Date ______________

APPOINTMENT CONFIRMATION PREFERENCE

To all Seven Oaks patients,

We will be making changes to our appointment reminder system,

Please check one of the following:

_____________________________________ would like to receive:

_____ A confirmation phone call

_____ A confirmation text message

_____ Do not call or text me to remind me

Preferred phone number for confirmation ____________________