SPORTS + ORTHOPEDIC LEADERS PHYSICAL THERAPY, INC.

Welcome to Sports and Orthopedic Leaders Physical Therapy, Inc. (SŌL PT). Thank you for choosing us as your physical therapy provider. Our entire staff is committed to serving you and making your rehabilitation experience enjoyable and successful. Please take a few minutes to read this information so that you can become familiar with our practice. We will be happy to answer any questions you have on an individual basis.

The physical therapy services provided by SŌL PT at this location are not part of a group practice or partnership. Your physical therapy care is exclusively provided by SŌL PT and no other individual or entity providing other services at this location. Should you require treatments or services other than those provided by SŌL PT, separate agreements and consent forms with such practitioners and professionals will be required prior to treatment. SŌL PT is not responsible for any treatments or services provided by other licensed practitioners or professionals – even if such treatments or services are provided in the shared SŌL Santa Cruz facility.

Mission Statement
SŌL PT is committed to excellence in the provision of physical therapy and wellness services to our valued clients and referring physicians. We strive to provide an exemplary model of physical therapy and fitness in a professional, caring, results-effective, cost-effective environment. Our goal is to assess each patient to return to their highest functional level in work, sports or recreation. We will provide outstanding service to our clients utilizing an individualized, goal-oriented approach and dedication to provide them the foremost expertise that physical therapy has to offer.

Office Hours and Appointments

Monday, 8:00 AM – 6:00 PM
Tuesday, 8:00 AM – 6:00 PM
Wednesday, 8:00 AM – 6:00 PM
Thursday, 8:00 AM- 6:00 PM
Friday, 9:00 AM – 4:00PM
(Weekends are available on an exception basis)

Physical therapy hours are by appointment only. We will try to get you an appointment within 24-hours. We appreciate your personal schedules and will make every effort to accommodate your special scheduling needs. We require 24-hour notice for any schedule changes.

Attire
Please dress comfortably as if you were going to exercise.

A Word About Physical Therapy
In the state of California physical therapists can see you without a medical referral. However for physical therapy injury treatment, a diagnosis must be in place. If you have a specific injury you will need a referral and diagnosis from a medical doctor or chiropractor. Most insurance companies require a physical therapy prescription that documents "medical necessity" for treatment. For fitness purposes, performance, wellness or maintenance visits, a physical therapy prescription is not needed. These visits are not considered medically necessary, therefore reimbursements are typically not provided by insurance and payment will be due at time of service.

Many people seek physical therapy with declining function, whether it be a postsurgical issue, an acute injury/trauma, chronic disease or condition, de-conditioning, complex pain, stress overload, or repetitive overuse injuries. These situations may be reimbursed by some insurance plans. Physical therapy treatment involves mobility planning/skilled interventions, and is based on movement impairment models. Goals are established at the time of examination and will relate to improving one's physical functioning.

When your therapist believes you have obtained your functional goals and improved functional status related to activities of daily living, or you plateau with progress, medical insurance will no longer apply. We as physical therapists are required to practice within this context.

If you elect to continue with our care, payment will be due at time of service. Many of our patients become lifelong clients and continue with visits for prevention, maintenance and performance which may include, consults, nutrition, active release, exercise programming, massage and fitness training.

OFFICE POLICIES:

Scheduling

When using insurance, a current prescription signed by a medical doctor is required for treatment and must be updated every 30 days. If treatment continues for a prolonged period, prescriptions must be updated regularly and coordinated with your medical doctor. You are responsible for these updates. Let us know when you will be seeing your physician so we can have a progress report ready.

Medicare patients are required to consult with their physicians every 60 days while receiving physical therapy. Please let us know when you are seeing your M.D. so we can have a progress report ready.

Physical therapy prescriptions are required for treatment. Please schedule well in advance, especially if you need special hours. You are responsible for these updates. Wellness visits do not require a physician referral. These visits are not reimbursed by insurance and payment is due at time of service.

A Word About Insurance

We are preferred providers for many health plans. In addition, if you have a personal injury/automobile accident with individual coverage, you are a Medicare patient, or have a Worker's Compensation injury, we do submit these claims and bill directly for you based on our ability to obtain prior authorization for your treatment.

Physical therapy coverage is often confusing. Although we can assist you with your insurance questions, it is strongly suggested that you contact your insurer directly to determine your coverage for outpatient physical therapy. You may be required to make deductible or co-insurance payments as part of your coverage. Customary method of billing for physical therapy services is based on the amount and type of services you receive, therefore we cannot tell you exactly how much your treatments will cost. However, once we have verified your coverage we can notify you of your approximate coverage. Please feel free to talk to our billing staff regarding your insurance questions.

You may or may not carry insurance under which a percentage of our fees are covered. You should know that all professional services provided by SŌL PT are charged directly to the patient, and that he or she (or the financially responsible party) is personally responsible for payment. While we cannot render service on the assumption that our fees will be paid by an insurance company, we will help prepare your insurance claim forms to confirm services payable by your insurance company.

Patients are responsible for services not covered by their insurance, including care that their insurance deems as **"not medically necessary"** even though a physician may recommend the treatment.

Patients are ultimately responsible for knowing the details of their coverage (e.g. percent of coverage, deductibles, co-payments, limits on number of visits or dates of coverage, your referring physicians' or our status as a preferred provider), which may determine the extent of your financial responsibility.

We do not accept liens against pending litigation settlements.

Financial Payment Arrangements

It is our policy to maintain your account on a current basis. **Charges for treatment are due at the time the service is provided unless we are preferred providers of your insurance plan.** We ask that you make co-payments, co-insurance and deductibles at the time of each visit. Your balance must be paid in full on or before the 1st day of the following month, and any unpaid balance will be considered past due on the 5th of the month. An interest charge of **1%** per month may be applied to all past due balances.

Voluntary Termination of Care

It is also our policy that if you choose to suspend or terminate your care and treatment, any outstanding fees for professional services rendered to you will be immediately due and payable.

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 plan 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 at the time of service, estimated co-insurance amount, and deductibles.
- To promptly pay any fees deemed the patient's responsibility indicated by their insurance carrier.

- To facilitate in claims payment by contacting their insurance carrier when claims have not been paid.

It is SŌL PT's responsibility:

- To provide quality medical care.
- To file insurance claims as a courtesy to the patient. A 60-day period will be extended for pending insurance payments, after which the patient may be held responsible for the entire balance.
- To provide a super bill for submission to the patient's insurance provider if we are not part of the patient's insurance network.

Cancellations and No-Shows
We require 24-hour notice in the event of a cancellation. There is a full $65.00 service fee for no-shows or cancellations without proper notice. Late arrival by 15 minutes or greater will be treated as a cancellation or no-show. This charge is not covered by your insurance and is billed directly to the patient and is due at the time of the next scheduled appointment. Repeated missed appointments may warrant discontinuance of care.

Financial Policy Acknowledgment:
I have read and understand the above financial policies and the cancellation policy. I agree to pay for the missed appointment fee and understand that, regardless of my insurance claim status or absence of insurance coverage, I am ultimately responsible for the balance on my account for any services rendered.

____ ____________________
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 Sports and Orthopedic Leaders Physical Therapy, Inc. I also authorize my insurance carrier(s) to make payments directly to Sports and Orthopedic Leaders Physical Therapy, Inc.

____ ____________________
Patient or Responsible Party Signature Date

I have read and agree to the above policies.

____ ____________________
Patient and/or Guardian Signature Date

SPORTS + ORTHOPEDIC LEADERS PHYSICAL THERAPY, INC.
EXPLANATION OF PROCEDURES

Welcome to our practice. You are here because you have been referred to us by your doctor for physical therapy. Physical therapy is defined as: "The evaluation, treatment or prevention of disability, injury, disease or other condition of health using physical, chemical and mechanical means including, but not limited to, heat, cold, light, air, water, sound, electricity, massage, mobilization and therapeutic exercise…."

Here is an explanation of some of the physical therapy procedures and modalities that you may receive during your course of treatment with us. Please make sure that if you have any questions you ask your Physical Therapist (PT) to answer them to your satisfaction.

PHYSICAL THERAPY EVALUATION (97001): This includes taking comprehensive history, systems review, and tests and measurements. The PT will formulate an assessment, prognosis and note anticipated intervention.

PHYSICAL THERAPY RE-EVALUATION (97002): The PT examines the patient and updates goals and treatment plan.

THERAPEUTIC EXERCISE (97110): Therapeutic exercises to develop strength and endurance, range of motion and flexibility.

NEUROMUSCULAR RE-EDUCATION (97112): Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture and proprioception.

MANUAL THERAPY (97140): Manual therapy techniques may include mobilization, manipulation, manual lymphatic drainage, manual traction, soft tissue mobilization.

THERAPEUTIC ACTIVITIES (97530): Use of dynamic activities to improve functional performance (activities such as bending, lifting, carrying, reaching, etc. and have as a goal to improve your functional performance in a progressive manner).

ELECTRICAL STIMULATION (97014) & ULTRASOUND (97035): These are physical agents, used in conjunction with the other treatments to reduce pain, inflammation, etc.

GAIT TRAINING (97116): Gait training activities including stair climbing.

SELF CARE, HOME MANAGEMENT TRAINING/ADL TRAINING, SAFETY PROCEDURES ETC. (97535)

COLD LASER (99999): Specifically, cold laser therapy: Modality used for pain relief, increased cell metabolism, and neuromuscular reeducation.

STRAPPING (KNEE – 29530, SHOULDER – 29240) OR TAPING (A4452): Strapping or taping of a specific body part for stability.

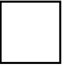
BY SIGNING THIS DOCUMENT I ACKNOWLEDGE AND UNDERSTAND THAT I MAY RECEIVE A NUMBER OF THE ABOVE LISTED SERVICES AND ALL OF MY QUESTIONS WERE ANSWERED BY THE TREATING THERAPIST TO MY SATISFACTION.

____________________	____________________	________
Patient's Name	**Signature**	**Date**

1. American Physical Therapy Association. Guide to Physical Therapy Practice. Alexandria, VA: APTA; 1999
2. HCFA Medicare. Physical Medicine & Rehabilitation. Policy Number (YPF#86) (YMED #09) MNB Medicare; 2002.

CONDITIONS & CONSENT FOR PHYSICAL THERAPY

The physical therapy services provided by Sports and Orthopedic Leaders Physical Therapy, Inc. (SŌL PT) at this location are not part of a group practice or partnership. Your physical therapy care is exclusively provided by SŌL PT and no other individual or entity providing other services at this location. Should you require treatments or services other than those provided by SŌL PT, separate agreements and consent forms with such practitioners and professionals will be required prior to treatment. SŌL PT is not responsible for any treatments or services provided by other licensed practitioners or professionals – even if such treatments or services are provided in the shared SŌL Santa Cruz facility.



Please initial here

Informed consent for treatment:

The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. The physical therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

Potential benefits may include an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Potential risks: I understand I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist.

No warranty: I understand that my physical therapist at SŌL PT cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will share with me his/her opinions regarding potential results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

I have read the above information and I consent to physical therapy evaluation and treatment. By initialing above and signing below, I acknowledge that I have read, understood and will abide by the conditions and policies noted on this consent form.

Print name ______________________ Date ______________________

Patient's signature (if minor, parent or legal guardian must sign) ______________________ Therapist signature/Date ______________________

MEDICAL HISTORY

Client/Patient: ______________________ Home Phone: ( ) ______________________

Date of Birth: ________Age: _____Work Phone: ( ) ____________Cell Phone: ( ) ______________

Address:______________________________City:__________State:______Zip:________

Social Security Number:____________________Email Address:______________________

Employer:____
Address State Zip

Emergency Contact: Name________________________Phone #:______________________

Address:____

Your goals for physical therapy:____

Athletic goals:______________________How did you hear about us?____________

Were you referred to a particular practitioner? If so, who?________________________

Referring Physician:______________________ Phone: ( ) ______________________

Address:____

When do you see your physician again?______________

Primary Care Physician:____________________ Phone: ( ) ______________________

Type of Injury/Condition:________________________ Onset/Injury Date:__________________

Physical limitations due to injury____

What activities aggravate your symptoms?______________________________________

Type of Surgery & Date:______________________

Describe any previous treatment for this condition:

____

Have you had any diagnostic tests for this condition?

X-ray CT scan MRI Doppler Ultrasound

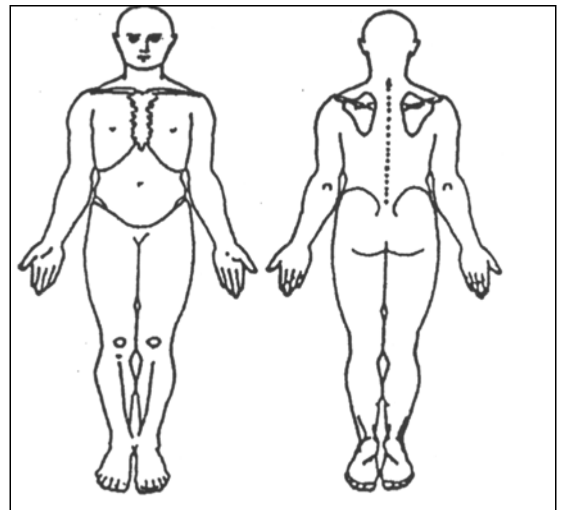
Please describe your pain: Sharp / Burning / Aching / Tingling / Numbness / Other______________________

Please rate your pain (0 = none, 1 = minimal, 10 = severe):

At present: : 0 1 2 3 4 5 6 7 8 9 10

At its worst: 0 1 2 3 4 5 6 7 8 9 10

At its best: 0 1 2 3 4 5 6 7 8 9 10



Please mark the location of your symptoms

Are you currently taking medications? Yes / No. Please list meds: ______________________________

____

Have you recently noted any of the following?

- ❒ Breathing Difficulty
- ❒ Change in Vision
- ❒ Fatigue
- ❒ Fever/Chills/Sweats
- ❒ Headaches
- ❒ Insomnia
- ❒ Nausea/Vomiting
- ❒ Pain at Night
- ❒ Pregnancy
- ❒ Weakness
- ❒ Weight Loss

Do you have now or have you ever had any of the following?

- ❒ Allergies/Skin Sensitivity
- ❒ Asthma/Breathing Problems
- ❒ Autoimmune Deficiency
- ❒ Cancer
- ❒ Circulation Problems
- ❒ Diabetes
- ❒ Easy Bruising/Bleeding
- ❒ Fainting
- ❒ Fractures
- ❒ Heart Problems
- ❒ Hepatitis
- ❒ High Blood Pressure
- ❒ Indigestion/Heartburn
- ❒ Kidney Disease
- ❒ Leg/Ankle Swelling
- ❒ Loss of Consciousness
- ❒ Lung Disease
- ❒ Metal Implant
- ❒ Motor Vehicle Accident
- ❒ Multiple Sclerosis
- ❒ Osteoporosis/Osteopenia
- ❒ Sprains/Strains
- ❒ Stroke
- ❒ Surgeries
- ❒ Thyroid Problems
- ❒ Urinary Problems/Infections

❒ Any previous injury that may affect current care? Please describe: ______________________________

Please explain & give approximate dates for any conditions marked above. ______________________________

____

____

INSURANCE INFORMATION

Insurance Carrier______________________________ Phone: ( )______________________

Address:____

Claim Number______________________________ Group Number______________________

Date of Injury______________ Adjustor or Contact Person______________________________

Name of Insured______________________________ Relationship to Patient__________________

Birth Date of Name of Insured____________________

Additional Insurance Coverage____________________ Claim Number______________________

Address____________________________________ Phone Number______________________

Did this accident occur at work? YES or NO   Were you involved in an automobile accident? YES or NO

Financial Class:

- ❒ Insurance ❒ In Network ❒ Out of Network
- ❒ Workers' Comp
- ❒ Wellness/Cash
- ❒ Other (select one): __Auto __Medicare

Dx: ____

Therapist: Moore McCormick

HIPAA REGULATIONS

Privacy Practices

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

Our Legal Duty

The law requires us to: 1) Keep your medical information private, 2) Give you notice describing our legal duties and privacy practices, 3) Notify you of any changes in our privacy practices. This is listed on our Web site: www.solpt.com.

Use and Disclosure

The following are different ways we are permitted to use and disclose medical information. Other than as specifically provided below, <u>we will not use or disclose any medical information without specific written authorization from you.</u>

Treatment: We may use medical information about you to provide you with medical treatment or other services related to your care. We may disclose medical information about you to doctors, nurses, technicians or other people involved in your care. We may also share medical information about you to *your* other health care providers to assist them in treating you.

Payment: We may use and disclose your medical information for payment purposes including to our service providers. A bill may be sent to you or a third party payer (i.e. insurance company, attorney, and/or consulting physician). We may also disclose information to your health plan about treatment or possible treatment to help determine if your health plan will pay for certain services.

If you have any question about any of our policies or your rights, please feel free to speak with your physical therapist or any of our staff.

Your signature below indicates your understanding and compliance with the above privacy practices.

____ ____________________
Printed Name Date

____
Signature

SŌL SANTA CRUZ DISCLOSURE FORM

Welcome to SŌL Santa Cruz, located at 1510 Seabright Avenue, Santa Cruz, California 95062. For my treatment, I am seeking the following:

Please initial on the appropriate line below:

_______ Chiropractic services provided by Karen K. Roitz, D.C., C.C.S.P.

_______ Physical Therapy services provided by Sports and Orthopedic Leaders Physical Therapy, Inc. (SŌL PT)

_______ Massage Therapy services

_______ Pilates Fitness services

By signing below, I hereby acknowledge and understand that SŌL Santa Cruz: (a) is the trade name under which various independent medical practitioners and professionals market their services and share office space; (b) does not provide any patient or other services; and (c) is not a group practice or partnership. All of the services offered at this location are provided by independent licensed practitioners or professionals, who will each require my individual consent prior to providing treatment or providing services, and who are solely responsible for my treatment or well being while at this facility. I further acknowledge and understand that should I require treatment by more than one named individual or entity above, I will be required to sign separate agreement and consent forms with such individual or entity prior to treatment. No other practitioners or professionals shall be responsible for my care or well being – even if such treatments or services are provided in the shared SŌL Santa Cruz facility.

☐ Please initial here

_______________________________ Print Name

_______________________________ Date

_______________________________ Signature

Active Release Techniques® and Graston® Soft Tissue Treatments Fee Notification

To Our Valued Patients:

We take great pride in providing the most current and results-driven physical therapy assessment and treatment techniques. Active Release Technique® (ART®) and Graston®/ASTYM are very effective at releasing scar tissue in the muscles, fascia and nerves. These techniques with our credentialed providers are an added benefit to your care with us and are solely offered outside of insurance coverage as of January 1, 2012.

If you choose these services with our credentialed providers, you will incur an additional charge of $40 to be collected at time of service or shortly thereafter that will not be covered as an insurance benefit. This is due to severely declining insurance reimbursement of less than 50% of our professional fees in the past 4 years in addition to the extensive additional board certifications and training required to provide these advanced techniques. We can no longer provide our customary high level of service without adequately being paid to maintain the viability of our practice.

PT benefits are limited. We are not getting paid for multiple procedures on the same day. Active Release Technique® and Graston®soft tissue techniques are no longer a part of physical therapy treatment unless you pay for it out-of-pocket. These sessions can be scheduled on an individual basis outside of your insurance visit. These charges are $150/comprehensive visit or $115 ART only. These services will not be billed to insurance. If you choose to bill your insurance and have ART® or Graston® on the same day of your physical therapy appointment, it is a $40 charge to be billed directly to you and is due at time of service. This fee is separate from any insurance copays or deductibles.

We have other effective forms of manual therapy available when coming to physical therapy that are covered under insurance such as PT-joint mobilization and soft tissue mobilization (general), so this is now your choice.

The following is a list of our physical therapists that are certified in the above named techniques:

Tammara Moore, DPT, ART – Lead ART® Instructor, Master Provider ART® Full Body/Graston®
Jill McCormick, PT, ART – ART® Full Body Certified

Thank you for your understanding.

Tammara Moore, DPT, OCS and associates

Patient Name (please print): ____
Patient Signature: ______________________________________ Date: __________________