



Welcome to SÖL Santa Cruz, formerly known as Seabright Spine and Sport. 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.

Physical therapy services at this location (SOL Santa Cruz) are provided by Sports & Orthopedic Leaders Physical Therapy, Inc. (SOL PT), a separate legal entity from the chiropractic services at this location.

Karen K. Roitz, DC, or Jamie L. Bjerkhoel, DC are independent Doctors of Chiropractic practicing under the DBA, SOL Santa Cruz, 1510 Seabright Avenue, Santa Cruz, CA 95062 and SOL PT, Inc. This office is not a group practice or partnership, but rather a facility where independent practitioners and SOL PT, Inc., share office space.

Physical therapy care is the exclusive responsibility of Lisa Gibson, DPT and Tammara Moore, DPT of Sports and Orthopedic Leaders Physical Therapy, Inc. and not of any other practitioners who also practice at this location.

Mission Statement

SÖL PT 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'll 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. However, for fitness purposes, performance, wellness or maintenance visits, a physical therapy prescription is not needed. These visits are not considered medically necessary, therefore not reimbursable by insurance and payment is 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, deconditioning, 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 no longer applies. We as physical therapists are required to practice within this context.

If you elect to continue with our care, we are able to see you on a payment at time of service basis. Many of our patients become lifelong clients and continue with visits for prevention, maintenance and performance. This may include consults, nutrition, active release, exercise programming, massage and fitness training at SÓL Santa Cruz.

*SOL Santa Cruz is committed to providing our patients with the highest quality care.
We thank you for taking the time to read and understand our policies.*

OFFICE POLICIES:

Scheduling

When using insurance, a current prescription signed by a medical doctor, and updated every 30 days, is required for treatment. 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 MD 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 Work Comp 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 SOL Santa Cruz 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.

Overall, 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, etc.), 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 in this office 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 the policy of this office that if you should 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 patient responsibility indicated by their insurance carrier.
- To facilitate in claims payment by contacting their insurance carrier when claims have not been paid.

It is SÖL Santa Cruz'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 payment, after which the patient may be held responsible for the entire balance.
- To provide a super bill for submission to insurance if we are not part of the patient's insurance network.

Cancellations and No-Shows

We require 24 hours notice in the event of cancellation. There is a full \$65 service fee for no-shows or cancellation 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 client, and will be collected 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 SÖL PT, Inc. I also authorize my insurance carrier(s) to make payment directly to SÖL PT, 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 SANTA CRUZ

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 the 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 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.

AQUATIC THERAPY (97113): Aquatic therapy with therapeutic exercises.

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

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 (97039 / 97139): Specifically, cold laser therapy: Modality used for pain relief, increased cell metabolism, and neuromuscular reeducation.

MASSAGE (97124): Effleurage, pétrissage and/or tapotement (stroking, compression, etc.).

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

BY SIGNING THIS DOCUMENT I ACKNOWLEDGE THAT I 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

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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 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 SOL PT, Inc. 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 /

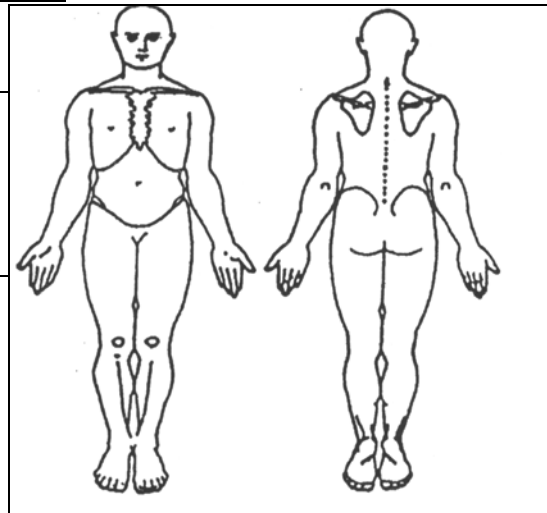
Tingling / Numbness / Other _____

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?

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Breathing Difficulty | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Change in Vision | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Fever/Chills/Sweats | <input type="checkbox"/> Pain at Night | |

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

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

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 Wellness/Cash
 Workers' Comp Other (select one): __Auto __Medicare

Dx: _____

Therapist: Moore Gibson

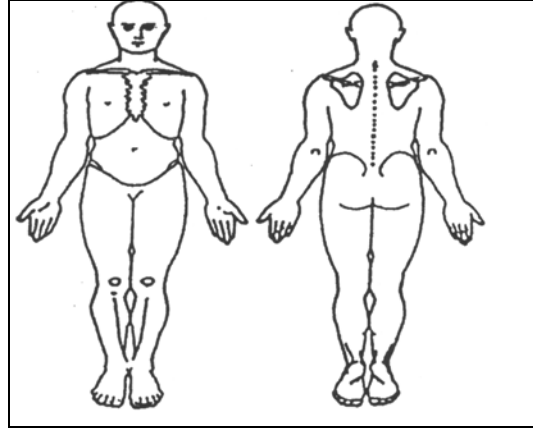
SÒL SANTA CRUZ
PATIENT HEALTH QUESTIONNAIRE

Patient Name _____ Date _____

1. Describe your symptoms _____

 a. When did your symptoms start? _____
 b. How did your symptoms begin? _____

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms.
 (1) Constantly (76-100% of the day)
 (2) Frequently (51-75% of the day)
 (3) Occasionally (26-50% of the day)
 (4) Intermittently (0-25% of the day)



Please mark the location of your symptoms

3. What describes the nature of your symptoms?
 (1) Sharp (4) Shooting
 (2) Dull ache (5) Burning
 (3) Numb (6) Tingling
4. How are your symptoms changing?
 (1) Getting Better
 (2) Not Changing
 (3) Getting Worse

5. During the past 4 weeks: None (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) Unbearable
 a. Indicate the average intensity of your symptoms _____
 b. How much has pain interfered with your normal work (including both work outside the home, and housework)?
 (1) Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely
6. During the past 4 weeks how much of the time has your condition interfered with your social activities? (like visiting with friends, relatives, etc.)
 (1) All of the time (2) Most of the time (3) Some of the time (4) A little of the time (5) None of the time
7. In general would you say your overall health right now is...
 (1) Excellent (2) Very Good (3) Good (4) Fair (5) Poor

8. Who have you seen for your symptoms? (1) No one (2) Medical Doctor
 (3) Chiropractor (4) Physical Therapist
 Other _____

- a. What treatment did you receive and when? _____
 b. What tests have you had for your symptoms and when were they performed?
 (1) X-rays date: _____ (3) CT Scan date: _____
 (2) MRI date: _____ (4) Other ___ date: _____

9. Have you had similar symptoms in the past? (1) Yes (2) No
 a. If you have received treatment in the past for the same or similar symptoms, who did you see?
 (1) This Office (3) Physical Therapist
 (2) Chiropractor (4) Medical Doctor
 Other _____

10. What is your occupation? (1) Professional/Executive (2) White Collar/Secretarial
 (3) Tradesperson (4) Laborer (5) Homemaker
 (6) FT Student (7) Retired (8) Other _____

a. If you are not retired, a homemaker, or a student, what is your current work status? _____



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

To follow are different ways that we are permitted to use and disclose medical information. We will not use or disclose any medical information not listed without specific written authorization from you.

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. A bill may be sent to you or a third party payer (i.e., insurance company, attorney, 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 of the above privacy practices.

Printed Name

Date

Signature