ASCEND
Physical Therapy & Balance Center

Personal Details			
NAME	SEX ☐ MALE ☐ FEMALE	AGE	DATE OF BIRTH
ADDRESS			
CITY STATE ZIP CODE			
PHONE Please check the number you prefer to be called at ☐ HOME ( ) _____ ☐ CELL ( ) _____	REFERRED BY: ☐ DOCTOR _____ ☐ OTHER _____		
EMAIL ☐ I prefer appointment reminders be sent to my email			

EMERGENCY CONTACT INFORMATION	
NAME	RELATION TO PATIENT
PHONE ( )	ALTERNATE ( )

All services furnished are charged directly to the patient. Patients are financially responsible for payment unless other arrangements have been made with the office management. It is our policy that payment be made at the same time services are rendered. We do not render services on the basis that insurance companies are financially responsible.

Relevant Injury Dates	
What date did you first experience symptoms related to your injury?	
If you had surgery for this issue, what was the date of the most recent surgery?	
If you started treatment at another facility on an earlier date, please add that date here.	

What is the main reason you are seeking medical attention? What problem can we help you solve?

What are your goals for therapy?

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Have you ever suffered from or been told you have any of the following?

- ☐ High blood pressure
- ☐ Heart problems
- ☐ Lung problems
- ☐ Head injury
- ☐ Multiple sclerosis
- ☐ Parkinson's disease
- ☐ Stroke
- ☐ Liver problems
- ☐ Thyroid problems
- ☐ Blood disorders
- ☐ Diabetes
- ☐ Low blood sugar
- ☐ Cancer
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Circulatory or vascular problems
- ☐ Broken bones (fractures)
- ☐ Other orthopedic problems
- ☐ Chronic pain
- ☐ Ulcers/stomach problems
- ☐ Chronic migraines
- ☐ Denies significant previous medical history

Medication List

Name	**Dosage**	**Frequency**	**Administration Route** (ex: oral, injection, etc.)	**What is it for?**

Please list any known allergies that you have.

I certify that the foregoing statements are true to the best of my knowledge and belief.

Signature of Patient	Date

Garden Grove: 12465 Lewis St. #101 Garden Grove, CA 92840 | P: 714-703-8477 | F: 714-703-8157
Buena Park: 5832 Beach Blvd. #114 Buena Park, CA 90621 | P: 714-707-2699 | F: 714-784-2160
Laguna Woods: 24361 El Toro Rd., #140 Laguna Woods, CA 92637 | P: 949-694-9988 | F: 949-694-9977

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LATE CANCELLATION OR NO-SHOW POLICY

A **24-hour notice** is required for an appointment to be rescheduled. If you need to reschedule, please call our office to arrange for a make-up appointment in the same week of the original appointment.

In an instance of a cancellation **without 24-hour notice or no-show** to a scheduled appointment, we reserve the right to charge a **$40 fee.**

If there's an emergency, we understand and can make an exception. More than 3 late occurrences, late cancellations or no shows will result in day-to day call in basis in order to schedule appointments. We reserve the right to discontinue care due to non-compliance and patient's failure to follow their established plan of care.

I certify that I have read, and understand, the above consent statements:

Patient or Patient's Guardian, Initials.

I agree to terms listed and all information provided is accurate. _____
Initials

NOTICE OF PRIVACY PRACTICES

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells how you can obtain access to this information.

As a patient, you have the following rights:
1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information;
6. The right to a paper copy of this Notice.

We want to assure you that you medical/protected health information is secure with us. This notice contains information about how we will insure that your information remains private. A complete copy of our privacy practices is available at any time in our waiting room or upon request. If you have any questions about this notice please contact the following Privacy Officer.

Effective Date of this Notice: 01/01/2021
Contact Person: Joseph Park— Privacy Officer
12465 Lewis Street. Suite 101 Garden Grove, CA 92840
Call: (714) 703-8477
Email: Joe@ascendpt.net

I hereby acknowledge that I have had the opportunity to review a copy of this practice's NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights that I may contact the privacy officer. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way during my course of treatment.
Patient or Patient's Guardian, signature.

I agree to terms listed and all information provided is accurate. _____
Initials

FINANCIAL RESPONSIBILITY POLICY

It is our policy and a courtesy to assist you in determining your physical therapy benefits; however, it is your responsibility to know your coverage. If there are any inconsistencies from the quoted benefits from your insurance company, bring it to our immediate attention as Ascend Physical Therapy, Inc. is not responsible for inaccurate information regarding insurance carrier or coverage provided.

It is also your responsibility to inform Ascend Physical Therapy, Inc. if you are actively receiving or plan to receive any of the following therapies during the course of your treatment at Ascend Physical Therapy, Inc. as it can affect your benefits: PT, OT, Speech, Chiro, Cardiac, Acupuncture or Hydro-Therapy.

Medicare patients cannot receive benefits for Medicare care Part B Outpatient Therapy and Medicare Part A Home Health Care at the same time. You must inform Ascend Physical Therapy if and when you enroll in a Home Health Care Episode while enrolled in outpatient physical therapy. This includes all forms of home health care not solely physical therapy. If I fail to report home health care to Ascend Physical Therapy, Inc. I understand that I will be responsible for any unpaid charges incurred during that time.

Assignment of Benefits/Release of Information: I hereby authorize my insurance benefits to be paid directly to Ascend Physical Therapy, Inc. for professional services rendered to me or my dependent. I understand that the co-pay/co-insurance information is my responsibility and will be due at time of service. I shall be personally responsible for any unpaid balance due. I authorize the release of any necessary medical information needed to process these claims.

I hereby agree to pay my account AS SERVICES ARE PROVIDED. If for any reason there is a balance owing on my account, I will pay promptly upon receipt of the statement. Although I have requested Ascend Physical Therapy to bill my insurance company on my behalf, I CLEARLY UNDERSTAND THAT I AM RESPONSIBLE DIRECTLY TO ASCEND PHYSICAL THERAPY, INC. FOR MY ACCOUNT REGARDLESS OF THE STATUS OF MY INSURANCE CLAIM.

I agree to terms listed and all information provided is accurate. _____
Initials

CONSENT TO TREATMENT

I hereby consent to the therapeutic procedures outlined below, to be performed by Ascend Physical Therapy, Inc. and their associates.

- I agree to be evaluated and treated for functional loss due to related nerve, muscle, and skeletal dysfunctions and/or pain.
- I understand that therapeutic procedures can include, but are not limited to: joint and soft tissue mobilization, home exercise programs, functional training including: posture and body mechanics, modalities, such as heat, ice, electrical stimulation, and ultrasound, and special procedures such as: taping, neuromuscular electrical stimulation, and bladder training.
- I understand that I will be explained the purpose of the therapeutic procedures prior to receiving treatment and that I may refuse any therapeutic procedure or treatment at any time.
- I understand that I may consult with other therapists and/or physicians at any time regarding my condition.

I agree to terms listed and all information provided is accurate. _____
Initials

I certify that I have read, and understand, the above consent statements that I have initialed.

_____ _____ ____
Printed Name Patient or Patient's Guardian, signature. Date