

Attach Medical Diagnosis Form here (Required)

Campus Physical Therapy Center

901 Campus Drive Suite 213 Daly City, CA 94015
650.994.7800 Fax: 650.240.1834

San Mateo Physical Therapy Center

101 San Mateo Drive Suite 202 San Mateo, CA 94401
Tel: 650.347.0200 Fax: 650.240.1834

Campus Physical Therapy Inc (CPT) appreciates the confidence you have shown in choosing us to provide your rehabilitation needs. Campus Physical Therapy Inc is a California Corporation DBA Campus Physical Therapy Center and San Mateo Physical Therapy Center and managed by Luis Araneda, PT, DPT. The referring physician(s) has no financial interest, no partnership, or no administrative decisions in Campus Physical Therapy Inc.

STATEMENT OF FINANCIAL RESPONSIBILITY

Form with input fields for LAST NAME, FIRST NAME, and ACCOUNT NUMBER (For Office Use Only)

The services I have selected to participate in implies a financial responsibility on my part. This responsibility obligates me to ensure payment in full of CPT fees. As a courtesy, CPT will bill my insurance carrier on my behalf. However, I am ultimately responsible for the payment of my bill. I am responsible for payment of any co-payment at the time of service and on receipt of a bill for any deductible / coinsurance as determined by the contract or explanation of benefits with my insurance carrier. Many insurance companies have additional stipulations that may affect my coverage. Please be advised that a quote of eligibility and benefits is not a guarantee of payment. All benefits are subject to the eligibility, medical necessity and the terms, conditions, limitations and exclusions of the patient's health benefit plan at the time of the services are rendered. I am responsible for any amount not covered by my insurer. If my insurance carrier denies any part of my claim, or if I, the referring physician or the physical therapist elect to continue therapy past my approved period, I will be responsible for my account's balance in full. I have read the above policy regarding my financial responsibility to CPT for providing rehabilitative services to the above named patient or myself. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize and instruct my insurer to pay any benefits directly to CPT. I agree to pay Campus Physical Therapy Inc the full and entire amount of all bills incurred by me or the above named patient, if applicable, any amount due after payment has been made by my insurance carrier. I further authorize Campus Physical Therapy to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment necessary to secure payment for services provided. I request and authorized my insurance carrier to provide with a complete written copy of the health plan contract that include a detailed descriptions of covered benefits and limitations of rehabilitation services upon request of Campus Physical Therapy Inc.

X

PRINT NAME AND RESPONSIBLE PARTY DATE

CREDIT CARD AUTHORIZATION

I authorize Campus Physical Therapy Inc to bill my credit card for co-payments, deductibles, the remaining of the balance, or for any amounts not paid by my insurance carrier.

Form with input fields for CREDIT CARD NUMBER, EXPIRATION DATE, SECURITY CODE, and LIMIT AMOUNT

X

PRINT NAME AND RESPONSIBLE PARTY DATE

GENERAL MEDICAL CONSENT TO TREATMENT

I have been informed about the expected benefit, and alternative methods of treatment(s), and I understand that I can refuse any procedure prior to its performance. I hereby consent to the procedure(s) which may be performed while I am a patient of Campus Physical Therapy, Inc. under the instructions of a Physical Therapist. This may include but not limited to: 1. Physical Therapy examination/ evaluation, physical performance test, 2. Application of modalities such as hot/cold pack, electrical stimulation, whirlpool, diathermy, ultraviolet, iontophoresis, phonophoresis, TENS, contrast bath, ultrasound,etc. 3. Application of therapeutic procedures that attempt to improve function including therapeutic exercises, neuromuscular rehabilitation, kinetic activities, gait training, manual or mechanical traction, massage, myofascial release techniques / soft tissue mobilization, joint mobilization, ADL's training, work hardening, group exercises, group education, etc.

X

PRINT NAME AND SIGNATURE PATIENT OR RESPONSIBLE PARTY DATE

PRIVACY PRACTICE ACKNOWLEDGEMENT

I acknowledge that the Notice of Privacy Practices is posted at the location in which I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have the right to request a copy of the notice

X

PRINT NAME AND SIGNATURE PATIENT OR RESPONSIBLE PARTY DATE

Important Company Policies

Campus Physical Therapy Center strives to provide the best personalized care available. To make this possible we adhere to a set of very important policies. Please read them carefully, initial all the boxes, and indicate your agreement by signing at the bottom.

____ **Late Policy “10 Minutes”** Being late more than 10 Minutes will require you to either reschedule or wait for the next available opening. There are no guarantees since opening due to cancellations are unpredictable. We do not allow appointment overlap because this undeservedly compromises the care of another patient.

____ **24 Hours Advance Notice Fee** If you wish to change or cancel an appointment we require a minimum 24-hour advance notice. Anything less will result in a \$10.00 fee charge to your account. It cost us money to make appointments available to you. Whether you attend or not we still accrue the expenses (staff wages, rent, etc). We don't charge you the actual cost for that appointment but rather a mere \$10.00. We do NOT make money with this charge. It's only to act as a deterrent from making last minutes changes. Advance notice allows someone else (who needs it) time to reserve it in place of you. Please be courteous and responsible. Thank you.

____ **Copays are due upon arrival** If you happen to forget your wallet or checkbook we may still be able to see you upon completion of an “Extension Request” form. This is a promise-to-pay” form and carries a minimal fee of \$5.00 dollars that allows you to keep your appointment.

____ **No-Shows are bad** Future appointment will be removed when you fail to show for an appointment without a 24-hour notice. A \$10.00 fee assessed to your account. You may reschedule appointments again on a “first come, first serve basis”

____ **Cell phone must be shut OFF or silent.** We realize emergency may arise and therefore allow you to carry your cell phone during your session, however, please be courteous and set to silent mode or turn off. Thank you

____ **Children requiring supervision and others are NOT allowed to attend sessions with you.** Because, we do not offers child care services, you may not bring children who require supervision with you to your appointments. If your child does not require supervision and is capable of waiting for you quietly then you may bring them. If any disturbance is caused to other patients, or staff members you may be asked to terminate your session early and attend your child. Due to Healthcare Privacy to you and other patients, your relatives, companions, and visitors must remain at the waiting room or the building lobby areas at all times. Exceptions are made if you need language, physical or other assistance.

____ **Financial Hardship** If you are experiencing financial difficulties and are unable to afford the cost of our services we have a “Financial Hardship Form which may be filled out. If you qualify for financial assistance according to the Federal guidelines, we may legally assist you by waiving or discounting your (patient responsibility) portions of the bill. Ask the front desk person, for assistance.

____ **Insurance ownership** I declare under penalty of perjury in the State of California that the insurance information is true and correct, this is not a third party (someone else) insurance, and that I am a direct beneficiary (self, spouse, child) of the policy holder.

____ **Important Notice from the Federal Government** It is unlawful to routinely avoid paying your copay, deductible, or coinsurance payment... even if your Physical Therapy Office allows it. Unless you complete a “Financial Hardship” form and qualify for financial assistance under the Federal Standards, you may not routinely evade paying your responsibility portions for medical care as outlined in your insurance plan even if your provider allows it. You both may be charged for breaking the law. This includes services deemed as “professional courtesy” and TWIP’s =“Take what insurance pays” Failure to comply place you in violation of the following Laws: Federal False Claim Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, States Insurance Fraud Laws, Failure to complaint may result in civil money penalty (CMP) in accordance with the new provision of the Health Insurance Portability and Accountability Act of 1986. Exceptional cases do apply. Please contact info for more information. Office of Inspector General, Department of Health and Human Services by phone: 202-619-1343 or by fax: 202.260.8512 by email. paffairs@oig.hhs.gov.

Name

Signature

Date

We look forward to building a relationship with you that will last a lifetime!