LEVAS PHYSICAL & OCCUPATIONAL THERAPY
9404 Genesee Avenue, Suite 310
La Jolla, California 92037

PLEASE PRINT THE FOLLOWING INFORMATION

Referred by: _____ Date of injury or onset: _____

Patient Name (Last) (First) (MI)	Sex	Date of Birth	Social Security Number
Home Address	City	State	Zip Code
Occupation	Marital Status	Spouse/Parent	
Employer	Address	Email Address	
Home Phone	Cell Phone	Employer Phone	Driver License

Nearest Relative/Emergency Contact

Name	Relationship	
Address		
Employer	Address	
Employer Phone	Home Phone	Cell Phone

ALL CASH PATIENTS AND PATIENTS WITH CO-PAYS MUST PAY AT THE TIME SERVICES ARE RENDERED

Please provide your insurance card and picture ID to the receptionist.
Then you may leave the section below blank.

Name of Primary insurance Carrier	Name of Secondary Insurance Carrier
Phone	Phone
Subscriber Name	Subscriber Name
Member ID#	Member ID#
Member Social Security Number	Member Social Security Number
Employer Name/Group Number	Employer Name/Group Number

Do you have an attorney representing this case? _____ Name _____

Phone Number _____ Was this a motor vehicle accident? _____

Our policy is that payment is due at the time services are rendered, unless other financial arrangements are made in advance.

I understand that upon verification of benefits from my insurance company, Levas Physical Therapy (LPT) will submit claims on my behalf to my insurance company. I also understand that that they have agreed to submit my claims as a courtesy to me, and that I am solely responsible for any deductible, co-pay or portion not covered by my insurance company. I agree to check my insurance benefit booklet and to verify my benefits with my insurance company as even though LPT will contact them for benefits on my behalf, they will not be held responsible for any coverage errors that my insurance company may have misquoted.

I authorize and assign my insurance benefits directly to LPT. I understand that a reasonable time period will be allowed for insurance to process and remit payment or explanation on claims submitted. At the time 90 days have lapsed and insurance has not responded, I understand that 50% of the account balance would be due, and a monthly payment arrangement would be established at that time. In the event that my account becomes delinquent and I have not responded to payment requests, then I authorized LPT to charge me an additional 50% of my account balance for collection expenses.

Please select your method of payment and sign below that you have read the above information.

_____ 1. HMO Account- Your co-pay is due at the time services are rendered. There will be an additional $5.00 billing fee for each co-pay NOT PAID at the time services are rendered.

_____ 2. PPO Account- If I have a set co-pay (example $5, $10, etc.) I will remit payment at the time services are rendered. If my co-pay is based on a percentage, I understand that I will be billed as insurance processes my claims. I understand that as I receive bills for my current portion due, it is due in full within 14 days. I understand that if I do not want to have to pay large lump sums of money (my deductible or percentage) then LPT advises me to make payments on my account as I receive services. I understand that I can make an appointment with the Administrator either by phone or in person to help me estimate a ballpark figure that I can pay as I receive services in an attempt to avoid having to pay a large bill after insurance begins processing my claims.

_____ 3. Cash Account- I understand that my payment is due either by cash, check, Visa or Mastercard at the time of each visit. I agree that if an administrative employee is not available at the front, I will leave my payment with my therapist.

_____ 4. Medicare Account- I have Medicare Part B, medical benefits coverage. I understand that if I have Part A, hospital coverage only, Medicare will not pay for my services at LPT. I understand that it is my responsibility to know my coverage. LPT is Medicare Certified. I understand that I am responsible for any deductible or co-insurance designated by Medicare.

_____ 5. Workman's Compensation- I have been notified that I have an approved claim with my employers workman's compensation carrier. I understand that with an authorization from the insurance carrier that I will not be liable for any financial obligations, other than missed appointment or late cancellation fee's of which I am solely financially responsible for.

_____ 6. Automobile Insurance- I am covered by my auto "med-pay" insurance. I understand that verification of 100% coverage will be required, with authorization of payment to be sent directly to LPT. I understand that no liens or settlements are accepted by LPT and any portion not paid by my insurance company is my sole responsibility.

Signature _____ Date _____

I authorize LPT to render treatment to _____ Age _____

Parent/Guardian _____ Date _____

Levas Physical & Occupational Therapy
9404 Genesee Avenue, Suite 310
La Jolla, California 92037

MEDICAL HISTORY

Name	Date	DOB	Male ☐ Female ☐

Have you had any of the following problems:	No	Yes	(If yes, please briefly explain)
High Blood Pressure	☐	☐	_____
Heart Trouble	☐	☐	_____
Circulation Trouble	☐	☐	_____
Dizzy Spells	☐	☐	_____
Diabetes	☐	☐	_____
Asthma	☐	☐	_____
Bronchitis	☐	☐	_____
Mental Illness	☐	☐	_____
HIV/Hepatitis	☐	☐	_____
Other Illness	☐	☐	_____

Have you ever has surgery? ☐ ☐ Year _____

Outcome: _____
_____

Do you have a cardiac (heart) pacemaker?	No ☐	Yes ☐
Do you have any metal anywhere in your body (other than teeth)	No ☐	Yes ☐
Are you now pregnant?	No ☐	Yes ☐
Do you have any trouble with vision?	No ☐	Yes ☐
Do you have any trouble with hearing?	No ☐	Yes ☐

List any allergies:

_____

_____

List all medications you are presently taking:

_____

_____

Have you ever had physical or occupational therapy before? No ☐ Yes ☐

When?

_____

Where?

_____

Problem Treated:

_____

Length of treatment:

_____

Please describe present problem or injury:

_____

_____

_____

_____

Patient's Signature: _____ Date _____

I authorize Levas Physical & Occupational Therapy to render treatment to the above listed minor whether I am present or absent (If patient is under 18 years of age).
Parent/Guardian: _____Date_____

Levas Physical & Occupational Therapy
9404 Genesee Avenue, Suite 310
La Jolla, California 92037

MISSED APPOINTMENT POLICY

F you cannot keep an appointment, advanced notice of 24 hours is requires. There is a $25.00 late cancellation fee that will apply to persons canceling their appointment with less that 24 hours notice. We do not bill this fee to your insurance carrier. This amount will be your responsibility to pay by your next scheduled visit. We do allow each patient one missed appointment/late cancellation, without charging a fee. Please save this one for a true emergency.

Please Note: Phone calls do not relieve you of your responsibility for this fee unless you have called 24 hours in advance. Please respect this policy. If you cannot come in at your scheduled appointment time, we will do our best to work with you to get you in at another time that day to avoid a missed appointment fee. Initial _____

I understand that it is my responsibility to attend physical/occupational therapy appointments on time. I also understand that failure to attend therapy in a consistent manner, per my doctors orders could result in discharge by my therapist.

FINANCIAL POLICY: I understand that I am responsible for any amount of my charges not paid by my insurance company.

I understand that Levas Physical & Occupational Therapy does not accept liens or settlements.

I hereby authorize Levas Physical & Occupational Therapy to provide information to insurance carriers concerning my illness/injury and treatment; and hereby assign to Levas Physical & Occupational Therapy all payments for medical services rendered to my dependents or myself. I authorize and give consent for treatment to be administered at Levas Physical & Occupational Therapy to my dependents or myself. A photocopy of this is considered to be as valid as the original.

Signature _____

Signature _____
(Parent or Guardian)