FABRIZIO PHYSICAL THERAPY & SPORTS MEDICINE, INC.

10309 Santa Monica Blvd, Suite 200
Century City, CA 90025
Office: 310-553-5984 Fax: 310-553-5986

Please note that we require a valid signature on all forms. You can email the forms back to us at reception@fabrizioptsm.com or bring the forms in with you at your appointment.

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First Name: **Last Name:** _____ **DOB:** _____

_____

Cellphone: _____ **Email:** _____

Home Phone: _____

Address: _____

_____

Referring Doctor: _____ **Dr's Contact:** _____

How did you hear about us? _____

EMERGENCY CONTACT

First Name: _____ **Last Name:** _____

Cellphone: _____ **Email:** _____

Patient Consent Please Initial

_____ **Consent for Care and Treatment**
I, the undersigned, hereby agree and give my consent for above named practice to furnish care and treatment considered necessary and proper in treating my condition.

_____ **Authorization for Signature on File and Release of Information**
I, the undersigned, hereby authorize the office of above named practice to affix my name to any and all claims or documents as related to any and all health benefits due me. I authorize the release of any information relating to my health care claims. A copy of this authorization shall be as valid as an original.

_____ **Authorization for Assignment of Benefits**
I, the undersigned, hereby assign all medical benefits, to which I am entitled, to the office of above named practice, and I shall be financially responsible for any unpaid balance. In the event payment is made directly to me for services rendered by this office, I recognize the obligation to promptly remit payment to this office. I hereby authorize and instruct my insurance company to pay by check and mail directly to above named practice.

_____ **Financial Responsibility**
I, the undersigned, understand and agree that if it becomes necessary to commence legal action, I am responsible for 30% interest if sent to collection agency and including any court costs, fees and attorney fees, in addition to my outstanding account balance. I further understand that balances over 60 days will be subject to a 1.5% finance charge, for which I am personally liable.

CONTINUE ON NEXT PAGE

_____ 24 Hour Cancellation Policy
Specific time is reserved for you when you schedule an appointment. If you cannot keep your scheduled appointment, please give us at least 24-hour notice so that we may reschedule your appointment and offer the reserved time to another patient. There will be a charge of **$150.00 for NO SHOW appointments or cancellations** with less than 24-hour notification. I, the undersigned, understand that I will be personally responsible for any cancellation fees

_____ Appointment Reminder Message
I, the undersigned, hereby authorize the office of above named practice to send reminders to my mobile number, home phone, or email address of upcoming appointments.

Fabrizio Physical Therapy & Sports Medicine, Inc. complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability sex or sexual orientation. Fabrizio PTSM does not exclude people or treat them differently because of race, color, national origin, age, disability sex or sexual orientation. If you feel discriminated against on the basis of race, color, national origin, age, disability, sex or sexual orientation you can file a written grievance with Rachel Fabrizio, Office Manager at 310-553-5984

Fabrizio Physical Therapy & Sports Medicine, Inc. is a HIPPA compliant facility. Please read HIPPA patient information located on our website at www.fabrizioptsm.com under forms.

I have read and fully understand all of the above information and hereby agree to comply as outlined above.

Patient or Guardian Signature **Date**

Patient Information Acknowledgement
I have read and fully understand above named practice's Notice of Information Practices. I understand that above named practice may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that above named practice will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in above named practice 's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient or Guardian Signature **Date**

CONTINUE ON NEXT PAGE

Information Release Authorization
I hereby consent to the release and disclosure of my personal health information to:

Physicians Name:_____

Address:_____

City: _____ **State:**_____ **Zip:**_____

Phone #: _____ **Fax #:** _____

For the following purpose: To help with the management of my care.
This release authorization includes my personal health information consisting of: Health records, notes, evaluations, progress charts, and any information that would pertain to my care with Fabrizio Physical Therapy & Sports Medicine, Inc.

I understand that the information outlined in this release will be disclosed according to the instructions of this release within two (2) business days of the above practice having received this release authorization. I understand that I am free to revoke this release authorization at any time by notifying the practice in writing. I also understand that the information disclosed under this release is subject to re-disclosure and no longer protected by the Privacy Regulations (45 C.F.R. 164).

_____ _____
Patient or Guardian Signature **Date**

CONTINUE ON NEXT PAGE

Fabrizio Physical Therapy & Sports Medicine, Inc.

BUSINESS POLICIES & CREDIT CARD AUTHORIZATION RELEASE

Fabrizio Physical Therapy takes pride in the quality of care we offer our patients. As such the office does not double book appointment times and strives to keep your wait time minimal. In order to do this we have a strict **24-hour cancelation policy.** Please read and sign below. We reserve the time exclusively for you. Therefore, if you reschedule/cancel in less then 1 business day prior to your appointment or do not show as scheduled, we will impose a charge for the full amount of your visit Cancelation charges are not copay charges. Insurance will not pay for canceled appointments. **In case of last minute emergency, exceptions will be made.** Due to the long list of patients who desire appointments, we ask you to please call our office should you need to cancel or reschedule. You must arrive on time for each appointment as we cannot guarantee you will be seen if you are late. You must also sign in for each appointment as to keep record of your visits.

I, _____ **(patient name)** authorize Fabrizio Physical Therapy & Sports Medicine, Inc. to charge the credit card on file/and or given below for cancelation fees, outstanding balances, and insurance co-payments or related charges.

Select card type: Visa / AMEX / Mastercard

_ _ _ _ - _ _ _ _ - _ _ _ _ - _ _ _ _ EX: _ _ / _ _ Security Code _ _ _ _

_____ _____

Patient or Guardian Signature **Date**

PAYMENT AND INSURANCE: We are "out of network" with all insurances except Medicare and Blue Shield. **David Fabrizio is out of network for most insurances.** As the responsible party, you assume full liability for charges accrued in this office. We will submit insurance claims to all in and out of network insurances.

David Fabrizio bills an hourly rate: Initial consultation is $300.00 and each follow up visit is $230.00. These rates are nonnegotiable. We will do our best to bill your insurance for out of network. We cannot confirm that insurance will pay.

I (print name) _____declare that I have read the above and agreed to its terms and charges. I had adequate time to inspect and question its contents.

CONTINUE ON NEXT PAGE

MEDICAL RECORDS INDIVIDUALS AUTHORIZATION FORM

I _____**(patient name)** hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees

First & Last Name: _____

First & Last Name: _____

_____ _____

Patient or Guardian Signature **Date**