550 St. Charles Drive, Suite #100
Thousand Oaks, CA 91360
Telephone: (805) 777-1023
Fax: (805) 777-3493 or (888)506-7977

400 Camarillo Ranch Road, Suite #108
Camarillo, CA 93012
Telephone: (805) 388-3055
Fax: (805) 388-3611

www.telesisphysicaltherapy.com

Patient Information:

Name _____

Address _____Apt#:_____

City _____State_____Zip_____

Social Security Number _____ Sex: M F Date of Birth _____

Home Telephone _____Cellular Telephone _____

Email Address _____

Employer Name _____Occupation _____

Employer Address _____City _____State _____Zip _____

Employer Telephone _____

Who referred you to our office? _____

Insurance/Billing Information:

***Please mark which apply:*

☐ Private Insurance

Please provide us with a copy of your insurance card

Do you have a secondary insurance you would like us to bill? Yes No

Please provide us with a copy of your insurance card

☐ Do you have Tricare/TriWest/Military Insurance? Please provide the Sponsor's Social Security Number

Sponsor's Social Security Number _____Sponsor's Date of Birth _____

Please provide us with a copy of your insurance card

☐ Workers' Compensation

Employer at time of injury _____

Date of Injury _____

Are you working with an Attorney? Yes No

If yes, Name of Attorney _____

Attorney Address _____City _____State _____Zip _____

Attorney Telephone _____

☐ Medicare

Please provide us with a copy of your insurance card

Do you have a secondary insurance you would like us to bill? Yes No

If yes, please provide us with a copy of your secondary insurance card

If yes, which insurance is primary? _____

☐ Auto/Other Accident _____ Date of Accident _____

Are you working with an Attorney? Yes No

If yes, Name of Attorney _____

Attorney Address _____City _____State _____Zip _____

Attorney Telephone _____

OVER ---------->>

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT OF SERVICES RENDERED.

Having insurance is not a substitute for payment. Many insurance companies have fixed allowances or percentages based on **your** contract with them. It is your responsibility to pay the deductible, co-insurance, and any other balances not paid for by your insurance. We will assist you in receiving reimbursement but you are ultimately responsible for your bill.

You will be sent statements which will reflect any payments made by your insurance company on your behalf. Patient statements will be sent to the address you provide on page one - it is imperative that our office is notified of any address changes for either yourself or your insurance company so that proper follow up and collection efforts may be completed in a timely manner.

In order to accommodate all our patients, we ask for a courtesy telephone call if you are unable to make a scheduled appointment. If you fail to give a 24-hour notice, you will be charged a $35.00 fee.

To our Medicare Patients: Medicare requires you to have a written prescription from your doctor every 30 days for physical therapy. Any visits not covered by your prescription will be your responsibility; therefore it is crucial that you have a written prescription every 30 days. Please notify your Physical Therapist of the day and time of your monthly doctor appointment so a progress note can be written to your doctor.
Please understand that Telesis PT has no way of knowing if or how much therapy you may have had at another Physical Therapy clinic. It cannot be determined as to when you have met your limit until Medicare receives and denys your claims, therfore we will reduce your denied services down to our discounted cash rate as a courtesy.

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to Telesis Physical Therapy, Inc. for any Physical Therapy and/or Medical benefits otherwise payable to me for services rendered.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Telesis Physical Therapy, Inc. to release any information required by my insurance company to process claims.

HIPAA AUTHORIZATION/PRIVACY PRACTICES ACKNOWLEDGEMENT: I hereby acknowledge that I have been notified of the Privacy Practices of Telesis Physical Therapy, Inc. and have been provided an opportunity to review it.

I agree to be financially responsible for all charges. I have read this information and I understand it.

Patient (Please Print) _____Date _____
If Minor, Guardian Name _____Guardian Date of Birth _____
Signature _____Date _____