

**WELLSPRING THERAPY, INC.**  
*The source for healing*

500 West Glenoaks Blvd., Glendale, CA 91202  
 3700 Park Place., Montrose, CA 91020

Tel: 818-637-2127 Fax: 818-637-2126  
 Tel: 818 249-8815 Fax: 818-249-8814

Date \_\_\_\_\_  
 Fecha \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Seguro Social

History **Have you ever been a patient at Wellspring Therapy?** Y N  
 Historia *Ha sido alguna vez paciente de Wellspring Therapy?* S N

Referring Physician \_\_\_\_\_  
 Médico

Date of Injury or Onset of Illness \_\_\_\_\_  
 Fecha del dano

Primary Physician \_\_\_\_\_  
 Familia Médico

Whom may we thank for referring you? \_\_\_\_\_  
 ¿A quién agradeceríamos por la referencia?

Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Teléfono

May we contact him/her? Yes No  
 ¿Podemos comunicarnos con él/ella?

**PATIENT INFORMATION/INFORMACION DEL PACIENTE**

Legal Name (Last, First, Middle) \_\_\_\_\_  
 Nombre Legal (Apellido, Primer Nombre)

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Dirección (No P.O. Box) Ciudad Estado Zip

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex M F  
 Teléfono Teléfono celular Fecha de Nacimiento Sexo M F

E-mail Address: \_\_\_\_\_

California Driver's License # \_\_\_\_\_ Patient Status Single Married Other  
 Numero de Licencia de California Circle all that apply Employed Full-time student Part-time Student

Employer \_\_\_\_\_  
 Empleo

Employer Address \_\_\_\_\_  
 Dirección De Empleo

Employer Phone (\_\_\_\_) \_\_\_\_\_ Your Occupation \_\_\_\_\_  
 Teléfono de Empleo Ocupación

In case of emergency who should be notified? \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_  
 En caso de emergencia a quién notificamos Teléfono

**PRIMARY INSURANCE INFORMATION/ INFORMACION DE SEGURO PRINCIPAL**

Insurance Company Name \_\_\_\_\_  
 Compañía de seguro

Insurance Address (To Mail Claims) \_\_\_\_\_  
 Dirección (Para Rediamos)

Phone Number to Verify Benefits (\_\_\_\_) \_\_\_\_\_ Adjustor/Contact Name \_\_\_\_\_  
 Teléfono para Verificar Beneficios

Insured or Guarantor Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Sex: M F  
 Nombre del Asegurado Parentesco con el Paciente

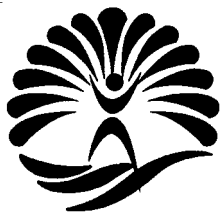
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Dirección Ciudad Estado Zip

Home Phone (\_\_\_\_) \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Employer Name \_\_\_\_\_  
 Teléfono Fecha de Nacimiento Nombre Empleo

Social Security Number of the Insured Person \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Número de Seguro Social la Persona Asegurada

Policy/Claim Number \_\_\_\_\_ Group Number \_\_\_\_\_  
 Número de Poliza Número de Grupo

Check if injured at work and covered by Worker's Compensation insurance.  
 Marque si el daño ocurrió en el y si fue cubierto por el seguro de compensación de trabajador



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Health History Questionnaire

Name \_\_\_\_\_

Date \_\_\_\_\_

To help us with your therapy, please indicate whether you have experienced any medical problems related to the following:

- |                             | Yes                      | No                       |                     | Yes                      | No                       |
|-----------------------------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|
| • Chest Pain                | <input type="checkbox"/> | <input type="checkbox"/> | • Asthma            | <input type="checkbox"/> | <input type="checkbox"/> |
| • Arrhythmia                | <input type="checkbox"/> | <input type="checkbox"/> | • Dizziness         | <input type="checkbox"/> | <input type="checkbox"/> |
| • Pacemaker                 | <input type="checkbox"/> | <input type="checkbox"/> | • Seizures          | <input type="checkbox"/> | <input type="checkbox"/> |
| • High Blood Pressure       | <input type="checkbox"/> | <input type="checkbox"/> | • Diabetes          | <input type="checkbox"/> | <input type="checkbox"/> |
| • Stroke                    | <input type="checkbox"/> | <input type="checkbox"/> | • Cancer            | <input type="checkbox"/> | <input type="checkbox"/> |
| • Short of Breath           | <input type="checkbox"/> | <input type="checkbox"/> | • Arthritis         | <input type="checkbox"/> | <input type="checkbox"/> |
| • Smoking                   | <input type="checkbox"/> | <input type="checkbox"/> | • Headaches         | <input type="checkbox"/> | <input type="checkbox"/> |
| • Chronic Cough             | <input type="checkbox"/> | <input type="checkbox"/> | • Current Pregnant  | <input type="checkbox"/> | <input type="checkbox"/> |
| • Hepatitis/HIV Positive/TB | <input type="checkbox"/> | <input type="checkbox"/> | • Loss of Sensation | <input type="checkbox"/> | <input type="checkbox"/> |

Other Illnesses: \_\_\_\_\_

Surgery History: \_\_\_\_\_

Metal Implants in Body: \_\_\_\_\_

Medications: \_\_\_\_\_

Pain: Your pain is:  Constant  Intermittent

On a scale of 0-10, (0—no pain, 10-- most painful), your pain is \_\_\_\_\_

Location of your pain: \_\_\_\_\_

Prior Therapy: Yes\_\_\_ No\_\_\_ If yes, was it helpful? \_\_\_\_\_

Sports & Activities (bowling, golf, jogging, etc): \_\_\_\_\_

Previous episode of this problem? \_\_\_ Yes \_\_\_ No If yes, please describe: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_



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## **Cancellation and No-Show Policy**

We strive to provide our patients with the highest quality of care and service. We are committed to your wellbeing—and the restoration of your physical abilities is something that everyone in our clinic takes seriously.

Because we care very much about you, we emphasize the importance of your own commitment to therapy. We know from experience that this is essential for your recovery.

Your adherence to the recommended number of treatments is a vital component of your progress. Thus we have certain rules that need to be followed in order to ensure the most optimum results.

We expect you to keep ***all*** your appointments. *Write down the time of your visits so that you do not forget.*

With the exception of serious emergencies, it is expected that you will keep all your appointments. If you need to re-schedule an appointment, we require 24 hours notice. In such a case, please call our office and arrange for a make-up appointment with our Front Desk Receptionist. The make-up appointment needs to be in the same week, preferably the very next day.

**There is a \$50 charge for a no-show or cancellation without 24-hour notice. The charge will not be covered by your insurance, but will have to be paid by you personally. We will also require a credit card number on file to reserve your next appointment, and we will charge your credit card for any future cancellations without proper notice.**

**If you are late for your appointment, we will try to accommodate you. However, you may not receive full treatment as scheduled.**

For Worker's Compensation and Personal Injury patients, we are required to forward documentation of any missed appointments to your case manager and primary physician. This could jeopardize your claim.

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care and to inform your physician that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

I have read and understand this policy: \_\_\_\_\_  
Patient Signature

Date: \_\_\_\_\_

**Important Information for All Patients**

**TREATMENT AND FINANCIAL POLICIES**

Thank you for entrusting Wellspring Therapy Inc. with your treatment. In order to ensure the best therapy for every patient, we operate under the following policies:

**Release of Medical Record:** In order to facilitate your treatment, you request that all of your medical records relevant to treatment be released to Wellspring Therapy Inc. A copy of this release shall be considered to be as valid as the original. We may use and disclose medical information about you to provide you with medical treatment or services, for payment purposes, for our health care operations. You have the right to review our privacy notice. You also have the right to request restrictions on how information about you may be used and disclosed for treatment, payment, and health care operations. This release shall be in effect until revoked.

**Consent for Care:** You hereby give your consent to the staff of Wellspring Therapy Inc. to provide therapy care and services prescribed by your physician, both verbally and written, and to exercise professional judgment regarding any additional care and services that may be necessary. You understand that you are expected to ask any questions you may have regarding your treatment. You are aware that therapy may result in one or all of the following: increased pain, swelling, redness, burning sensations, or wound bleeding.

**Appointment/Compliance:** Arrive for your appointment **on time**. If you are late, you may not get your full treatment, but will be billed for the time scheduled for you. **Sign in** at the front desk when you arrive. We request a 24-hour **cancellation notice** of a scheduled appointment so that we may offer that time to another patient. Failure to do so will result in a \$ 50.00 fee due and payable at the following visit.

**Billing and Insurance:** Please indicate your medical insurance plan by checking one of the following:

\_\_\_\_\_ Workers Compensation Insurance. We will request authorization from your workers compensation insurance carrier on your behalf. You will not be responsible for costs incurred by the authorized treatment. You agree that Wellspring Therapy Inc. may release your medical record to your insurance company for billing purposes. We are also obligated to inform your insurance carrier and/or your employer if appointments are not kept or compliance with your program is not met.

\_\_\_\_\_ Medicare Insurance. We accept Medicare assignment and will bill National Heritage Insurance Company for you. By law, you are responsible for the 20% co-payment as well as any deductible. You will be billed for any co-payment or deductible after we receive the Medicare Explanation of Benefits. Balances that remain after 45 days from billing will be subject to interest up to maximum of 1.5% per month, but not in excess of the maximum interest rate allowed by law. There is a \$25 fee for returned checks.

\_\_\_\_\_ Other Insurance Plan. Our office will, as a courtesy to you, contact your insurance company to request information regarding your deductible, co-payment, and the terms of coverage for our services. We will inform you of their quote to us but it is not a guarantee of their cooperation or payment. Your insurance policy is a contract between you and your insurance carrier. Wellspring Therapy Inc. is not a party to that contract. Wellspring Therapy Inc. (is) (is not) a participating provider. **Your deductible and co-payment are due at the time of services.** Your co-payment for therapy is \$ \_\_\_\_\_. There is a \$25.00 fee for returned checks. Most policies allow six weeks from the date of treatment for payment. If your insurance carrier does not remit payment within 45 days, the patient is responsible for the outstanding balance, including co-payments, deductibles and any percentage insurance does not cover. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your medical insurance. We reserve the right to charge interest on the outstanding balance up to 1.5% per month, but not in excess of the maximum interest allowed by law. If it becomes necessary for the account to be referred to an attorney for collection or suit, you are liable for reasonable attorney's fees and collection expenses.

**Please sign below, indicating that you have read the above and understand and agree to the terms set forth.** By your signature, you further agree to final and binding arbitration for any and all claims, disputes or controversies arising between you and Wellspring Therapy Inc., whether contractual, statutory or common law. You additionally agree to waive your rights to a jury trial and to utilize the services of, and to arbitrate under the then rules promulgated by, the American Arbitration Association.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_ Date \_\_\_\_\_