**APPLICATION for PHYSICAL THERAPY SERVICES**

This application, if approved, will provide you with up to ten visits of Physical Therapy (PT) services, at no cost to you, at a physical therapy clinic that has collaborated with us in giving quality physical therapy services. Before completing this application, check our website to be sure that we have partnered with a physical therapy clinic in or near a city where you live. Please contact us if you cannot find a PT clinic in your area.

*We look forward to helping you receive the physical rehabilitation services you need.*

I. BASIC INFORMATION

Full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_\_\_

Gender: Male Female

Race:\* Which of the following best describes your racial background? (please circle)

American Indian or Alaska Native Asian Black or African American

Hispanic or Latino Native Hawaiian or Other Pacific Islander

Two or More Prominent Races White

\*This information is required for us to keep and report for statistical purposes only and to ensure that we are serving persons from the entire spectrum of racial backgrounds. PTFORALL does not discriminate based on gender, race, national origin, religion, age, sexual orientation, marital status or disability.

Are you a U.S. citizen? Yes No

Complete Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

II. HEALTH INSURANCE

Do you have health insurance?

 YES Name of Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Do they pay for PT services? YES NO

 Do you have a co-pay for PT services? YES NO

 Amount of your co-pay? $\_\_\_\_\_\_\_\_\_\_\_\_

 Is there an annual deductible that has to be met, if so: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Has your deductible been met? YES NO

 NO

III. FINANCIAL INFORMATION

Any financial information you provide will remain confidential. Proof of financial hardship is necessary for us to consider funding your physical therapy services.

We require a copy of the first page of your latest federal tax return.

NOTE: Please black out your social security number on any documents you submit.

Annual Income of Client (self) $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check one:

Employed Unemployed Since \_\_\_\_\_\_\_\_\_ Retired Since \_\_\_\_\_\_\_\_\_

Permanent disability Since \_\_\_\_\_\_\_\_\_

What is your disability due to (back pain, head injury, spinal cord injury, etc.)? \_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Source of Income (Please list all sources such as employment, SSI, Child Support, Alimony, etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Monthly Gross Income \_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Monthly Gross Income \_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Monthly Gross Income \_\_\_\_\_\_\_\_\_\_

Total Monthly Income \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Since \_\_\_\_\_\_\_\_\_

Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Annual Income of SPOUSE $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Not Applicable - Single

 Own Home since \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rent

How many dependents live in your home? (A dependent is a person who relies on another as a primary source of [income](http://en.wikipedia.org/wiki/Income) such as a child under 19.) \_\_\_\_\_\_\_\_\_

Assets**\***: Please describe assets such as checking and savings account balances and trusts. Please include settlements related to your disability, if applicable.

(Checking) Bank Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Balance $ \_\_\_\_\_\_\_\_\_\_

(Savings) Bank Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Balance $ \_\_\_\_\_\_\_\_\_\_

(Trust Accounts) Bank Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Balance $ \_\_\_\_\_\_\_\_\_\_

(Settlement) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Value $\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Balance/Value $ \_\_\_\_\_\_\_\_

**\***We reserve the right to request copies of bank statements.

IV.PHYSICAL THERAPY SERVICES

Do you have a referral/prescription from a physician for physical therapy services?

\_\_\_\_YES \_\_\_\_NO (If “NO”, then please skip to question #1 on next page)

Name of your referring physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis for which you have been referred to physical therapy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please attach a copy of your physical therapy referral to this application.**

IV.PHYSICAL THERAPY SERVICES(continued)

1) Please explain in detail why you need physical therapy. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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2) Have you received physical therapy in the past for this specific condition?

\_\_\_\_YES \_\_\_\_NO If yes, when and where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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If yes, did your medical insurance cover the previous visits? \_\_\_\_YES \_\_\_\_NO

3) Please list the date and give a brief description of any injuries or surgeries related to your current need for physical therapy. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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4) Please list any/all diagnoses you have been given by a licensed physician.

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5) Please list any/all physical impairmentsyou currently have:

 High or Low Tone  Poor coordination  Ataxia  Hemiplegia  Poor balance

 Paralysis  Limb loss  Weakness  Joint stiffness  Contractures

 Pain (location/severity)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Other (please list)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6) Please check the activities that your physical impairment substantially limits or prevents you from accomplishing.

 Dressing  Toileting  Eating  Feeding Yourself  Sitting Up

 Bathing/Showering  Transferring  Standing  Lifting 15 lbs

 Sleeping  Cooking  Reaching  Driving  Working (normal job duties)

 Walking using your normal assistive device (walker or cane)

 Self propelling your wheelchair

When you are in the “best of health”, which assistive device do you normally use? power wheelchair, scooter, wheelchair, walker, cane, none, other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other comments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7) Please share any other relevant information we may have missed. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following documents must be attached to this application:\*

1. First page of your latest federal tax return
2. Physician referral/prescription for physical therapy services (if you have one)
3. PT Services Liability Release form

\*Please black-out your social security number on any documents submitted.

The undersigned hereby states that all of the above information is true. The undersigned also understands that Physical Therapy For All reserves the right to reclaim any money paid out, and seek restitution from the applicant, if any evidence of fraud or misrepresentation of applicant’s physical injuries, impairments or financial status is uncovered.

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

Signature of applicant

**Please mail the completed application with the attachments above to:**

**Physical Therapy For All**

**31022 Via Mirador**

**San Juan Capistrano, CA 92675**

** PT SERVICES PATIENT LIABILITY RELEASE**

If I am accepted into the PT Services Program, I acknowledge and accept full responsibility for the physical therapy care that I receive at a clinic that has partnered with PTFORALL.

I understand the following to be true:

1. PTFORALL makes no guarantees about the quality of physical therapy services that I may receive.
2. I have the right to stop physical therapy at any time for any reason.
3. PTFORALL will only pay for physical therapy services at clinics on our list of physical therapy service providers.
4. If I am unable to attend an appointment, I will be courteous and call the physical therapy clinic to cancel, as there is no penalty for cancelling 24 hours ahead of time.  If I do not, I am responsible for any fees the PT clinic charges for late cancellations and “no shows”.
5. I will be dropped from the program for one “no show” or two late cancellations.
6. The physical therapy office where I receive my care will send their PT treatment notes regarding my care, along with the bill for PT services, to PTFORALL. This is to ensure that PTFORALL is only paying for treatments delivered by a licensed PT or PTA and to verify that I am receiving good care.
7. PTFORALL has no ownership interests in any of the physical therapy clinics or rehabilitation centers listed on our website.
8. I must contact PTFORALL immediately if I am not satisfied with my care:

 Barbara Gray 949.735.9955 barbara@ptforall.org

I hereby release, discharge, and covenant not to sue PTFORALL, its officers, board of directors, volunteers and employees (each of the forgoing shall be considered one of the releasees herein) from all liability, claims, demands, losses, or damages related to any injuries, pain, suffering or adverse outcomes I may sustain while receiving physical therapy care under this PT Services Program at a clinic that has partnered with PTFORALL, and agree to hold harmless each of the releasees from any litigation expenses, attorney fees, loss, liability, damage, or cost which may be incurred as the result of such claim.

**I acknowledge that I have read this agreement** and fully understand its terms, have signed it freely, and have voluntarily entered into this agreement at my own risk.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please print full name

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

Signature of applicant