Physicians Choice Physical Therapy
A Professional Physical Therapy Company

PATIENT REGISTRATION FORM

Patient Name: _____ Social Security Number:_____-_____-_____

Date of Birth: _____/_____/_____ Sex: M / F (Circle one) Married/Single/ Divorced/ Widow

Address: _____

Home Phone: (_____) _____-_____ E-mail Address: _____

Cell Phone: (_____) _____-_____ Date of injury: _____

Employer Name: _____ Employer Phone Number: (_____) _____ - _____

Employer Address: _____

Primary Care Physician: _____Copay Amount $_____

Have you had PT, OT, Speech, Chiro, Accupuncture treatment this year? Yes No

If yes, how many total visits to date? _____

For Medicare patient, are you enrolled in Medicare Home Health? Yes No

Who referred you to us? _____

Is English your primary language? Y N If no, do you need an interpreter? Y N

Referring Physician: _____ Phone Number: (_____) _____-_____

Date of last visit to the Doctor: _____Diagnosis: _____

Prescription Frequency & Duration: _____

Referring Attorney: _____ Phone Number: (_____) _____-_____

Attorney's Address: _____

Person Responsible for bill or parent (Complete only if different from patient)

Guarantor Name: _____ Social Security Number: _____-_____- _____

Relationship to Patient: (please check): ( ) self, ( ) spouse, or ( ) parent Date of Birth: _____/_____/_____

Address: _____ Phone Number: (____) - ____ - _____

Employer Name: _____ Employer Phone Number: (_____) _____ - _____

Employer Address: _____

(Street) (City/State/Zip)

Who to call for an emergency:

Name: _____ Address: _____

Home Phone: (____) - ____ - _____ Work Phone: : (____) - ____ - _____ Relationship: _____

FIRST INSURANCE INFORMATION

Physicians Choice Physical Therapy
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Plan Name: _____ I.D. Number: _____

Address: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Holder's Social Security Number : _____ - _____- _____

Policy Holder's Date of Birth: _____/_____/_____ Sex: M / F

SECOND INSURANCE INFORMATION

Plan Name: _____ I.D. Number: _____

Address: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Holder's Social Security Number : _____ - _____- _____

Policy Holder's Date of Birth: _____/_____/_____ Sex: M / F

For office use only:

Insurance name: _____Contact person: _____

Deductible: $ _____ How much was met to date? $_____ Insurance coverage: ____% Copay: $_____

Total number of Physical Therapy Visits allowed per year: _____

Remarks: _____

_____

IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT? (circle one) YES NO

IF YES, PLEASE NOTIFY THE RECEPTIONIST

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Physicians Choice Physical Therapy. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature: _____ Date: _____

PATIENT NAME: _____

Consent for Care and Treatment

I, the undersigned, hereby agree and give my consent for Physicians Choice Physical Therapy to furnish care and treatment considered necessary and proper in treating my condition.

Authorization for Signature and Release of Information

I, the undersigned, hereby authorize the office of the Physicians Choice Physical Therapy to affix my name to any and all claims or documents as it relates to any and all health information due to me. I authorize the release of any information relating to my healthcare claims. A photo scanned 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 Physicians Choice Physical Therapy, and I shall be financially responsible for any unpaid balance in the event that payment is made directly to me for services rendered by this office. I hereby authorize and instruct my insurance company to pay by check and mail it directly to:

Physicians Choice Physical Therapy
12113 Santa Monica Blvd., Suite 203
West Los Angeles, CA 90025

Financial Responsibility

I understand and agree that if it becomes necessary to commence legal action, I am responsible for all costs of collecting moneys owed including court costs, collection agency fees and attorney fees in addition to my outstanding account balance. I further understand that balances over 60 days old will be subject to a 1.5% finance charge, for which I am personally liable for.

Cancellation Policy

A specific time is reserved for you when you schedule an appointment. If you cannot keep your scheduled appointment, please notify us no later than 24 hours in advance so we may reschedule your appointment and offer the reserved time to another patient. You will be charged $50.00 for NO SHOW appointments or cancellations with less than 24 hours notice. You understand that you will be held personally responsible for any cancellation or No SHOW fees.

Grievence policy: Please call Gauravi Merchant, Director at 818-435-4455 regarding any grievence issues.

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

_____ _____

Patient or Guardian Signature Date

Statement of Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceedings.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during the recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.

We may contact you by phone, mail or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

- ➢ You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- ➢ You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- ➢ You have the right to inspect and copy your health information
- ➢ You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- ➢ You have a right to an accounting of disclosures of your protected health information made by us.
- ➢ You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at 818.435.4455. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer by calling this office at 818.435.4455. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Star Rehab Corp with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____
Patient's Name (print)

_____
Patient's Signature Date

_____
Authorized Facility Signature Date

PATIENT MEDICAL HISTORY

Date today: ____/____/____
Patient Name: _____ Sex: M / F Birthdate: ____/____/____

Have you ever had or currently have:	**If yes, please explain**	**Family History**

High Blood Pressure	No	Yes	No	Yes
Heart or Circulation Disorder	No	Yes	No	Yes
Seizures	No	Yes	No	Yes
Dizzy Spells	No	Yes	No	Yes
Diabetes	No	Yes	No	Yes
Cancer	No	Yes	No	Yes
Arthritis/Osteoarthritis	No	Yes	No	Yes
Immune Deficiency Disease	No	Yes	No	Yes
Depression	No	Yes	No	Yes
Incontinent of Bowel or Bladder	No	Yes	No	Yes
Abnormal Vision or Hearing	No	Yes	No	Yes
Angina or Chest Pain	No	Yes	No	Yes
Shortness of Breath	No	Yes	No	Yes
Urinary Tract Infection	No	Yes	No	Yes
Metal Implant or Pacemaker in Body	No	Yes	No	Yes
Allergies	No	Yes	No	Yes
Unusual Weight Gain/Loss Recently	No	Yes	No	Yes
Other	No	Yes	No	Yes

Please list surgeries you have had, please give procedures and dates, if possible: _____

_____

Please list any accidents or injuries you have had:_____

_____

Please list recent diagnostic studies (i.e. CAT Scan, MRI, X-rays):_____

_____

Other problems that have been diagnosed by a physician? Yes No

Please list all medications you are now taking: _____

_____

[For women only] Are you pregnant? Yes No Date of last menstrual cycle ____/____/____

Have you ever taken steroids or anti-coagulants for an extended period of time? Yes No

Have you ever had physical therapy treatments before? Yes No

If yes, please indicate where, and for what problem: _____

What are your goals in Physical Therapy? _____

Is English your primary language? Y N If no, do you need an interpreter? Y N

_____

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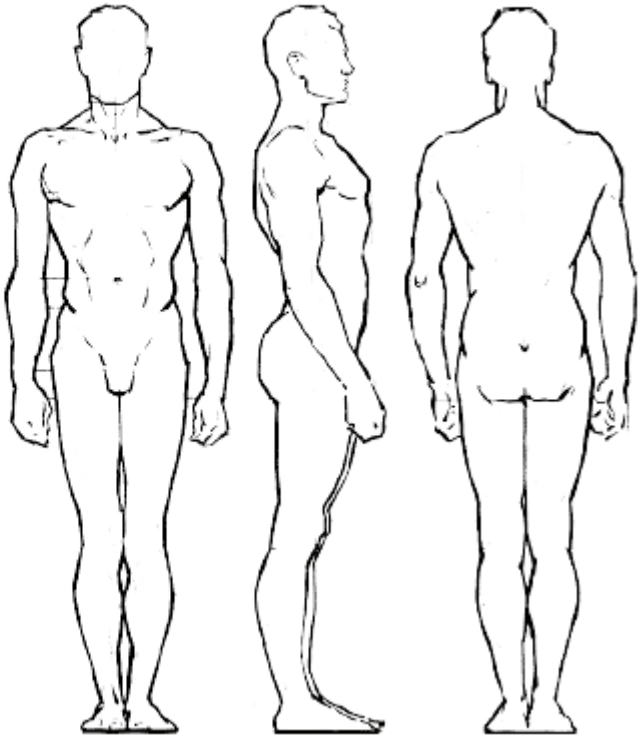
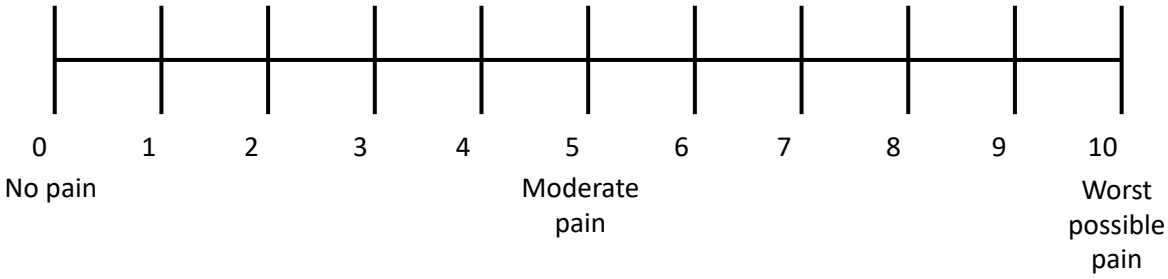
Draw the location of your pain on the body outlines using the following markers.

A = Aches
B = Burning
N = Numbness
P = Pins & Needles
S = Stabbing
O = Other



0-10 Numeric Pain Rating Scale



HISTORY OF FALLS:

Have you fallen in past year? YES NO

If yes, how many times?

A. 2X in past 6 in past 6 months
B. 1 – 2 times a year
C. Specify _____