

Palos Verdes Physical Therapy

Patient Registration Form

Date: _____

Primary Insurance: Medicare <input type="checkbox"/> Group Health <input type="checkbox"/> Workers Comp <input type="checkbox"/> Lien <input type="checkbox"/> Other <input type="checkbox"/>				Secondary Insurance: Medicare <input type="checkbox"/> Group Health <input type="checkbox"/> Workers Comp <input type="checkbox"/> Lien <input type="checkbox"/> Other <input type="checkbox"/>			
<input type="checkbox"/> New Patient <input type="checkbox"/> Re-Start <input type="checkbox"/> New Diagnosis <input type="checkbox"/> New Insurance				PTPN <input type="checkbox"/> Yes <input type="checkbox"/> No			
Patient #		Title	Patient Name (Last, First, Middle Initial)				
Address			City/State/Zip				
Home Phone ()		Work Phone ()		Email Address			
Social Security #		DOB	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Driver's License #	Financial Class		
Referring Physician			UPIN	Referring Physician Phone#	Treating Therapist		
Patient Status <input type="checkbox"/> Active <input type="checkbox"/> SFA		Primary location CLINIC	Marital Status	Student	Employment Status		
Occupation		Employer			Employer Phone #		
Address			City/State/Zip				
Emergency Contact (Name)			Home Phone ()	Work Phone ()			
Address			City/State/Zip		Relationship to Patient		

Financially Responsible Party Other than Patient

Name (First, Middle Initial, Last)				Relationship to Patient	
Address				City/State/Zip	
Home Phone ()		Work Phone ()		Email Address	
Social Security #		DOB	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Driver's License #	

Injury Information

Is condition surgery related? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Surgery	Surgical Procedure	
Is condition accident related? <input type="checkbox"/> Yes <input type="checkbox"/> No		Was an automobile involved? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Accident
Describe Accident				
Were you injured on the job? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Injury		Are you currently working? <input type="checkbox"/> Yes <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> No
Name of employer at time of accident			City, State, Zip Code	
Describe Injury				
Is litigation involved? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of Attorney		Phone # ()

-Office Use Only-

Diagnosis:			ICD-9 Code:		
Diagnosis:			ICD-9 Code:		
Diagnosis:			ICD-9 Code:		

Insurance Information

Were benefits and authorization verified? Yes No

Primary Insurance		In- network <input type="checkbox"/>	Out-of-network <input type="checkbox"/>	Pre-Certification <input type="checkbox"/> Yes <input type="checkbox"/> No		Visits per Year
Claims Mailing Address			City, State, Zip Code			
Subscriber Name		Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to Patient		
ID Card #(including alpha prefix)		Group #		Authorization #		
Claim #	Effective Date	Coverage%	Co-Ins%	Co-Pay by Specialty \$	Visits Remaining	
Deductible Start Amount \$	Deductible Remaining Amount \$		Pre-Certification Phone # ()			
Benefits Verified By	Date	Spoke to			Ins. Customer Service Phone # ()	

Secondary Insurance		In- network <input type="checkbox"/>					Out-of-network <input type="checkbox"/>
Claims Mailing Address			City, State, Zip Code				
Subscriber Name		Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to Patient			
ID Card #(including alpha prefix)		Group #		Authorization #			
Claim #	Effective Date	Coverage%	Co-Ins%	Co-Pay \$	Pre-Certification <input type="checkbox"/> Yes <input type="checkbox"/> No	Visits per Year	
Deductible Start Amount \$	Deductible Remaining Amount \$		Pre-Certification Phone # ()				
Benefits Verified By	Date	Spoke to			Ins. Customer Service Phone # ()		

The above description is a quote of your insurance(s) benefits. We assume no liability for any errors made by your insurance carrier(s) in this quotation. It is your responsibility to clarify any discrepancies in eligibility, benefits and/or authorization and inform our clinic immediately. We have reviewed these benefits with you. You understand and agree to pay any balance remaining after your insurance carrier(s) has paid its portion of the charges.

Patient Initials	Date	Front Office	Date

ASSIGNMENT OF INSURANCE BENEFITS

1. The undersigned agrees, whether signing as agent or patient, and it hereby individually obligated to pay for services rendered to the patient in accordance with the regular rates and terms of the company, which are not reimbursed by third parties. The undersigned further agrees to bear legal fees and collection expenses, which may be incurred by the company, in collection of payment on the amount, if that amount becomes delinquent.
2. The undersigned hereby authorizes treatment by Palos Verdes Physical Therapy and assigns to Palos Verdes Physical Therapy any and all benefits arising out of any type of insurance, which insures the patient's bill. The undersigned understands that the temporary acceptance of verified insurance coverage in lieu of payment does not release the patient from ultimate payment responsibilities.
3. The undersigned hereby authorizes Palos Verdes Physical Therapy to release any or all information to third parties, including but not limited to employers and insurance companies, who may be liable to the patient or Palos Verdes Physical Therapy for payment of charges to the patient.
4. Palos Verdes Physical Therapy reserves the right to modify the privacy practices outlined in the notice. The undersigned acknowledges having received a copy of the Notice of Privacy Practices for Palos Verdes Physical Therapy.

Patient Signature:	Date:
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CPM Office Use Only:	Entered by:	Date:
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Palos Verdes Physical Therapy

CURRENT MEDICAL HISTORY

Primary Complaint:	Can you localize your pain? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, where is your pain located? _____
How long have you had your symptoms? Days: _____ Weeks: _____ Months: _____ Date of Onset: _____	What is the quality of your pain? <input type="checkbox"/> Ache <input type="checkbox"/> Dull <input type="checkbox"/> Numbness <input type="checkbox"/> Sharp <input type="checkbox"/> Steady <input type="checkbox"/> Pulsating <input type="checkbox"/> Pins & Needles <input type="checkbox"/> Throbbing
Was the onset of your symptoms due to any of the following? (check all that apply)	Check the box next to the activities that RELIEVE your pain/symptoms:
<input type="checkbox"/> Chronic Symptoms	<input type="checkbox"/> Unknown Onset
<input type="checkbox"/> Motor Vehicle Accident	<input type="checkbox"/> Overuse
<input type="checkbox"/> Sports/Recreational	<input type="checkbox"/> Trauma
<input type="checkbox"/> Work Related	<input type="checkbox"/> Other:
What was the onset speed of your injury?	<input type="checkbox"/> Modifying your activities
<input type="checkbox"/> Gradual?	<input type="checkbox"/> Walking
<input type="checkbox"/> Insidious?	<input type="checkbox"/> Heat
<input type="checkbox"/> Sudden?	<input type="checkbox"/> Stopping activities
Did you have any of these diagnostic tests?	<input type="checkbox"/> Standing
<input type="checkbox"/> Bone Scan	<input type="checkbox"/> Lying Down
<input type="checkbox"/> Doppler Studies	<input type="checkbox"/> Medication
<input type="checkbox"/> NCV/EMG	<input type="checkbox"/> Heat
<input type="checkbox"/> Cardiac Stress Test	<input type="checkbox"/> Ice
Have you had prior episodes of this condition?	<input type="checkbox"/> Rest
<input type="checkbox"/> Yes <input type="checkbox"/> No (check one)	<input type="checkbox"/> Sitting
If Yes, how many? <input type="checkbox"/> 1 <input type="checkbox"/> 2-3 <input type="checkbox"/> 3-4 <input type="checkbox"/> 4+ <input type="checkbox"/> 10+	<input type="checkbox"/> Walking
Is the Severity: <input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing <input type="checkbox"/> No Change	<input type="checkbox"/> Medication
Date of Surgery, if any for this problem: _____	Does Pain awaken you at night? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes How many times/night? _____
Current Medications: _____	PAIN SCALE
	0 No Pain
	1 Mild pain: you are aware of it, but it doesn't bother you
	2 Mild pain: you become more aware of it, but only begins to bother you
	3 Moderate pain that you can tolerate without meds
	4 More severe pain that requires medication to tolerate
	5 Severe pain: you begin to feel antisocial
	6 Severe pain: you cannot participate in recreational activities
	7 Very severe pain: you cannot participate in activities of daily living
	8 Intensely severe pain: you cannot leave the house
	9 Extremely severe pain: you cannot get out of bed
	10 Most severe pain: you need to go to the hospital
	<i>Using the above scale what are your pain levels?</i>
	Now? At Best? At worst?

			Which best describes your health? (check below)	
What is your current work status?: (check below)			<input type="checkbox"/> Excellent	<input type="checkbox"/> Fair
<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time	<input type="checkbox"/> Regular Duty	<input type="checkbox"/> Good	<input type="checkbox"/> Poor
<input type="checkbox"/> Retired	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Restricted Duty		
<input type="checkbox"/> Other	<input type="checkbox"/> Disabled	What is your current Lifestyle?		
If not working, What was last day worked?			<input type="checkbox"/> Sedentary	<input type="checkbox"/> Physically Active
What is your Previous Functional Level?			What is your current Exercise Routine?	
<input type="checkbox"/> No limits with activities of daily living				
<input type="checkbox"/> No limits with work activities				
<input type="checkbox"/> No limits with recreational activities			What activities do you wish to return to?	
<input type="checkbox"/> Other				
What are your Goals/Reasons for treatment?				

PAST MEDICAL HISTORY

Have you been diagnosed with any of the following?								
	YES	NO		YES	NO		YES	NO
Allergies			Diabetes			Osteoporosis		
Anemia			Dizzy Spells			Parkinson's		
Anxiety			Emphysema/Bronchitis			Recent Fever		
Arthritis			Fractures			Rheumatoid Arthritis		
Asthma			Gallbladder Problems			Seizures		
Cancer			Hepatitis			Strokes		
Cardiac Conditions			High Blood Pressure			Thyroid Disease		
Cardiac Pacemaker			Incontinence			Tuberculosis		
Circulation Problems			Kidney Problems			Vision Problems		
Currently Pregnant			Metal Implants			Weight Loss		
Depression			Multiple Sclerosis					

Which treatments have you had for **YOUR CURRENT** condition?

Surgery Injection Physical Therapy Massage Therapy Chiropractic Acupuncture

Bed Rest Medication Other:

Have you had any previous Surgeries?	If Yes, Please list:	

PATIENT SIGNATURE:		DATE:	
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Palos Verdes Physical Therapy
NOTICE OF PATIENT INFORMATION PRACTICES

Effective April 13, 2003

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

Palos Verdes Physical Therapy's LEGAL DUTY

Palos Verdes Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Palos Verdes Physical Therapy uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, *Palos Verdes Physical Therapy* may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you, or to obtain Authorization, Verify your insurance benefits, Billing your insurance, and to inform your doctor your progress of treatment.

Palos Verdes Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, and for emergencies. We also provide information when required by law. For example, *Palos Verdes Physical Therapy* may be required to disclose your personal health information without authorization when requested by judicial administrative release, health oversight release, research, law enforcement, public health activities, coroner's or medical examiners for identification of deceased, and / or specialized government functions.

In any other situation, *Palos Verdes Physical Therapy*'s policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

For example, if *Palos Verdes Physical Therapy* would disclose your personal health information for marketing, fund raising, solicitation for research studies, management reporting and analysis. We, *Palos Verdes Physical Therapy* do not sell your personal health information to anyone.

Palos Verdes Physical Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. *Palos Verdes Physical Therapy* will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that *Palos Verdes Physical Therapy* may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on *Palos Verdes Physical Therapy*'s health information practices or if you have a complaint, please contact the following person:

Palos Verdes Physical Therapy
Office Administrator
28924 S Western Avenue, Suite101, Rancho Palos Verdes, CA 90275.
Telephone: 310.548.0104 Fax: 310.548.0559

Palos Verdes Physical Therapy
PATIENT INFORMATION CONSENT FORM

I have read and fully understand Palos Verdes Physical Therapy 's Notice of Information Practices. I understand that Palos Verdes Physical Therapy 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 Palos Verdes Physical Therapy 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 Palos Verdes Physical Therapy '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 Name

Signature

Date

I also authorize Palos Verdes Physical Therapy to use my protected health information for targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

Patient Name

Signature

Date