



# REGISTRATION FORM

(PLEASE PRINT)

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## PATIENT INFORMATION

Patient's Last Name		First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss	Marital Status (Circle One)	
				<input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Single / Mar / Div / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former Name)		Birth Date / /	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Residential Address/ P.O. Box			City	State	Zip Code	
Social Security #		Occupation			Home Phone No. ( )	
Employer		Employer Address			Employer Phone No. ( )	
Name of Primary Physician			City or Hospital Name		Physician Phone No. ( )	

## INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Date of Injury/Accident	Injury under litigation? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Attorney	Attorney Phone No. ( )
Is this a work related injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	Workman's Comp Claim filed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Employer at time of injury:	
Is injury from auto accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		Other accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, \$ amount limit on policy: \$		If yes, please specify:	

Name of Primary Insurance		Subscriber's/Policyholder Name	Birth Date / /	Subscriber's S.S. # - -
Policy #	Group #	Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		
Name of Secondary Insurance (if applicable)		Subscriber's Name	Group #	Subscriber's S.S. #
Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				

## IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )
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## ASSIGNMENT & RELEASE

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly and mailed to:

**Physical Therapy Innovations, Inc. 425 Kearney St. El Cerrito, CA 94530.**

If my policy prohibits direct payment to the health provider, then I hereby also instruct my insurance company to make the check out to me but **mail it care of Physical Therapy Innovations, Inc.**

I understand I am responsible for any amount not covered by my insurance, and for any costs incurred for collection on my account. I ALSO AUTHORIZE **PHYSICAL THERAPY INNOVATIONS, INC.** TO FURNISH INFORMATION TO MY INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

X \_\_\_\_\_  
PATIENT/GUARDIAN SIGNATURE DATE



## To Our Patients Regarding Billing, Payment and Office Policy

Thank you for choosing our practice. Please take time in reading the important information below. A copy can be provided upon request. Please see the receptionist with any questions.

- **To Patients using Health Insurance Plans or Medpay Insurance:** Financial responsibility for services rests with the patient. Our office will submit health insurance claim forms to your insurance plan. The patient portion is due at the time of service and any other balance is due within 30 days from the receipt of our billing to you.
- **To Patients with high deductibles.** You will be expected to pay towards your deductible at the time services are rendered at our current posted discounted self-pay rate. We will apply the amount paid towards your deductible. Please understand this rate is not necessarily the rate your insurance will process your claims at, and you may owe additional monies which will be billed to you after your claim is processed.
- **To Patients who are not using their insurance plans:** Payment is expected at the time services are rendered. We will not submit insurance claims for you. A bookkeeping courtesy discount will be given so that you will pay a discounted flat rate per visit. Please ask the front office regarding our fees.
- **No-show or Cancel less than 24 hours:** There is a \$75 charge for a missed appointment or cancellation without proper notice. This charge will not be covered by insurance, but will have to be paid by you personally. Even if it is a last minute cancellation, we greatly appreciate you notifying us so we can attempt to schedule our waiting list patients into your space. We are obligated to notify your physician about attendance or compliance issues, and your physician may decide to discontinue your course of therapy. Your commitment to attending your appointments, being here on time, and doing your home exercise program is critical for us to help you heal your injuries.
- **Records Requests and Outside Forms or Letters:** If for any reason you need to obtain a copy of your records, or need your physical therapist to fill out a form or write a letter in addition to what we generally provide to your referring doctor, please make the request in writing. There is a minimum processing fee of \$15 per request payable at the time of your request.

We outline our policies here because we want to avoid any potential misunderstandings.

*I acknowledge I have read and understand this notice.*

\_\_\_\_\_  
*Patient Signature (parent signature if patient is a minor)*

\_\_\_\_\_  
*Date*

We have an automated reminder call system which will call and remind you of your appointment the day before. This is done as a courtesy. You are responsible for knowing when your appointments are scheduled. If you do not wish to receive reminder calls or if there is an alternate telephone number you wish to be reached at, please inform our receptionist. Thank you.

**PHYSICAL THERAPY INNOVATIONS, INC.**  
**CONFIDENTIAL INFORMATION**

***Please tell us a little about your medical history:***

**Name:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_ **Age** \_\_\_\_\_  
**Date of Injury & How did injury take place (briefly):** \_\_\_\_\_

Have you had previous physical therapy for your present condition?      ! Yes      ! No  
If "Yes", please state when: \_\_\_\_\_ where: \_\_\_\_\_

**Please indicate whether you now have, or have ever had any of the following:**

<b>YES</b>	<b>NO</b>	<b>Nature of Problem</b>	<b>YES</b>	<b>NO</b>	<b>Nature of Problem</b>
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to Ice / Heat
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Currently pregnant
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease / heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Allergies / hay fever
<input type="checkbox"/>	<input type="checkbox"/>	History of cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hernia(s)
<input type="checkbox"/>	<input type="checkbox"/>	Pace-maker	<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Headaches / migraines	<input type="checkbox"/>	<input type="checkbox"/>	Metal implants / artificial joints
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease / stone(s)	<input type="checkbox"/>	<input type="checkbox"/>	Recent weight gain / loss
<input type="checkbox"/>	<input type="checkbox"/>	Bowel / bladder disorders	<input type="checkbox"/>	<input type="checkbox"/>	Menopause/Pre-menopause
<input type="checkbox"/>	<input type="checkbox"/>	Smoker/former smoker	<input type="checkbox"/>	<input type="checkbox"/>	Depression

Orthopaedic History:

<input type="checkbox"/>	<input type="checkbox"/>	Car accidents	<input type="checkbox"/>	<input type="checkbox"/>	Broken bones
<input type="checkbox"/>	<input type="checkbox"/>	Joint strains/sprains	<input type="checkbox"/>	<input type="checkbox"/>	History of back and neck pain

If "Yes" to any of the above, give dates and details (and list any other illness or problems not listed above): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you presently taking medication?  Yes       No      If "Yes", please list the medication(s) and relating condition:

<b>Medication</b>	<b>Relating Condition</b>
_____	_____
_____	_____
_____	_____

***The above information I've written is accurate to the best of my knowledge. If I've forgotten something, I'll be sure to inform you immediately.***

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

# Physical Therapy Innovations

## **NOTICE OF PATIENT INFORMATION PRACTICES**

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. A COPY IS AVAILABLE UPON REQUEST.

### OUR LEGAL DUTY

Effective 4/14/03, we are required by law to protect the privacy of your personal health information, to provide this notice about our information practices, and to follow the information practices described herein.

### USES AND DISCLOSURES OF HEALTH INFORMATION

We use your personal health information primarily for treatment, for obtaining payment for treatment, for conducting internal administrative activities, and for evaluating the quality of care that we provide. For example, we may use your personal health information to contact you to provide appointment reminders, or to provide you with information about treatment alternatives or other health-related benefits that could be of interest to you.

We may also use or disclose your personal health information without your prior authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We also provide information when required by law.

In any other situation, our 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.

We may change our policy at any time. When changes are made, a new Notice of Patient Information Practices will be posted in the waiting room and patient exam areas. You may also request an updated copy of our Notice of Patient 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 (we may charge you a nominal fee for providing you with copies of your records). 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 in which 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 situations.

We will consider all such requests on a case-by-case basis, but we are not legally required to accept them.

### CONCERNS AND COMPLAINTS

If you are concerned that we 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 us at the address listed below. You may also contact the U.S. Department of Health and Human Services to learn more about your privacy rights or to file a written complaint. For further information regarding our health information practices, or if you have a complaint, please contact us at:

**Physical Therapy Innovations**  
**HIPAA Compliance Officer**  
425 Kearney Street, El Cerrito, CA 94530  
Telephone: 510-524-2177 Fax: 510-525-2875

## Physical Therapy Innovations

### PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand your Notice of Patient Information Practices. I understand that you 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 you will consider requests for restriction on a case by case basis, but do 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 your Notice of Patient Information Practices. I understand that I retain the right to revoke this consent by notifying you in writing at any time. I also understand a copy of the notice is available to me upon my request.

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Patient Name

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Signature

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Date