New Patient Registration Form

- Please read and print carefully! -

The information you provide will help us provide you with an optimal recovery experience.

Patient Demographic Information			
First Name	M.I.	Last Name	Gender
Date of Birth	Social Security Number	Marital Status	

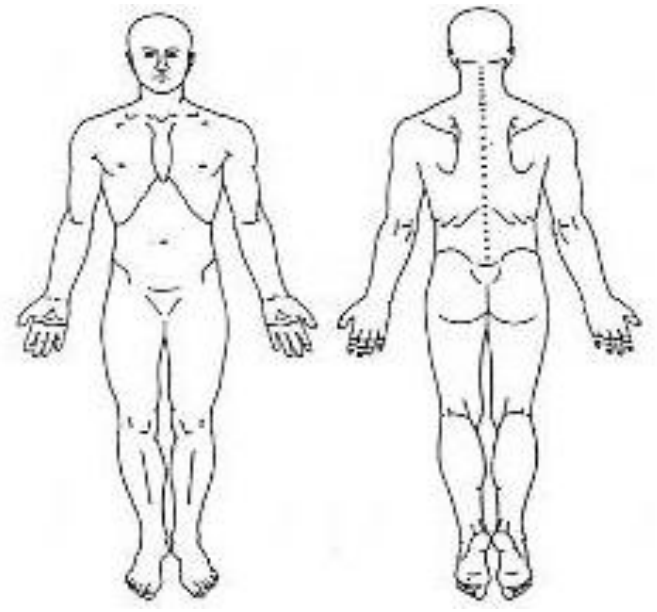
Emergency Contact		
Name	Relationship	Phone number

Patient Contact Information		
Street Address		Apartment/Unit #
City	State	ZIP
Home #:	E-mail Address	
Work #:	Preferred forms of contact (select two):	
Cell #:	□ Home □ Email □ Work □ Text message □ Cell □ Other:	

Insurance information		
SUBSCRIBER Name	Subscriber D.O.B.	Relationship to subscriber
Employer Name	Employer Phone Number	Occupation

Please be sure to have the front desk copy your insurance card!

I certify that the above information is true and correct to the best of my knowledge	
Patient/Guardian Signature X_____	Date

Patient Symptoms		
Referring Doctor	Regular Primary Care Doctor	Date of Injury/Onset
Occupation	Top recreational activities 1. 2. 3.	
Please describe how the injury occurred:		
Please describe your symptoms: _____ _____ _____		
Please rate your pain on a scale from 0 to 10:  What makes you feel better? What makes you feel worse?	Please shade the areas of your symptoms on the diagram below: 	
I certify that the above information is true and correct to the best of my knowledge		
Patient/Guardian Signature X_____		Date

Patient Medical History

Please mark which of the following medical conditions you have currently or have had in the past.

☐ High Blood Pressure ☐ Diabetes ☐ Stroke ☐ Heart Disease/Heart Attack ☐ Pace Maker ☐ Seizure ☐ Hernia ☐ Headaches ☐ Allergies ☐ Smoker/Former Smoker	☐ Recent hospitalization greater than one day ☐ Prior Surgery Which body part and where? _____ ☐ Car Accident ☐ Sprains and/or Strains ☐ Broken Bones ☐ History of Back and Neck Pain ☐ Pregnant ☐ Other:

Have you had previous physical therapy for your present condition? ☐ Yes ☐ No

If yes, please state when and where:

Please list any current medications:

1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

Please mention anything about your medical history that we might have missed in the above form:

I certify that the above information is true and correct to the best of my knowledge

Patient/Guardian Signature	Date
X_____	

Patient Acknowledgement and Consent Form

Authorized Designated Individuals

Please list below the individuals you would like to have access to your private health information. If you would prefer not to designate authorized individuals, please write "none" and sign.

Name	Relationship
Name	Relationship
Name	Relationship

I hereby authorize these designated parties to request and receive the release of any protected health information regarding my treatment, payment, or administrative operations related to treatment and payment. I understand that the identity of the designated parties must be verified before the release of any information.

Patient/Guardian Signature	Date
X_____	

Acknowledgment and Consent of Terms and Policies

By signing, I certify that I have read the attached documents "*Notice of Patient Information Practices*" and "*Note to Our Patients Regarding Billing, Payment, and Office Policy*" and furthermore agree to comply with terms of therein. These documents include but are not limited to the following clauses which I have read, understand, and with which I agree to comply:

I understand that cancelling my appointment with less than 24 hours of notice or failing to keep my appointment will result in a $75 fee, to be paid by me personally, NOT by my insurance!

I understand that Physical Therapy Innovations 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 copayment and deductibles are due at the time of service excepting pool therapy copayments which I may pay in advance or have billed to me. I authorize the participation of PT and PT assistant graduate candidates in my treatment. I understand that I am ultimately financially responsible for any services provided by Physical Therapy Innovations, Inc.

☐ I do NOT authorize Physical Therapy Innovations to use my information for marketing, fund-raising and solicitation.

I understand that these documents may be made available to me upon request.

Patient/Guardian Signature	Date
X_____	

Assignment and Release

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 <u>care of Physical Therapy Innovations, Inc</u>**. I understand I am responsible for any amount not covered by my insurance, and for any costs incurred for collection on my account. I authorize Physical Therapy Innovations, Inc. to furnish information concerning my illness and treatments to my insurance carriers. A photocopy of this assignment shall be considered as effective and valid as the original.

Patient/Guardian Signature	Date
X_____	