

WELCOME TO FOOTHILL PHYSICAL THERAPY

REGISTRATION FORM

Please mark the reason you chose Foothill Physical Therapy for your current condition:

- | | | |
|---|--|--|
| <input type="checkbox"/> Physician Referral | <input type="checkbox"/> Insurance Plan | <input type="checkbox"/> Advertisement _____ |
| <input type="checkbox"/> Close to Home | <input type="checkbox"/> Internet _____ | <input type="checkbox"/> Phone Book _____ |
| <input type="checkbox"/> Close to Work | <input type="checkbox"/> Family Member _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> American Physical Therapy Assoc. | <input type="checkbox"/> Friend _____ | |

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Name: _____

Address: _____ City: _____ State: _____ Zip: _____

SS#: _____ - _____ - _____ Birth Date: ____/____/____ Age: _____ Sex: Male Female

Marital Status: Single Married Legally Separated Divorced Widowed

Are you employed? Yes No Retired Are you disabled? Yes No Reason: _____

Are you a student? Full-time Part-time Non-student

Occupation: _____ Employer: _____

CONTACT INFORMATION

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

Cell Phone: (____) _____ - _____ Email Address: _____

My preferred method of correspondence is: Home Work Cell Email

In case of emergency please contact:

Name: _____ Relationship to Patient: _____

Home: (____) _____ - _____ Work: (____) _____ - _____ Cell: (____) _____ - _____

Primary Care Doctor's Name: _____ Phone: (____) _____ - _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the release of information during the course of my treatment at Foothill Physical Therapy including but not limited to medical records, verbal and written communications to my insurance company, employer, doctors, and third party payers.

I have received and read a copy of Foothill Physical Therapy's privacy procedures.

Patient Signature: _____ Date: _____

(Parent or Guardian if Minor)

HEALTH INSURANCE

Do you have health insurance? Yes No If yes please fill out below:

Insurance Name: _____ Name of Insured: _____

Insured's SS#: _____ - _____ - _____ Relationship to Insured: Self Child Spouse Other

Patient ID #: _____ Group #: _____

RESPONSIBLE PARTY

If you DO NOT have health insurance, please fill out below if someone else is paying your bill:

Name of person responsible for payment of services: _____

Relationship to Patient: _____ Phone Number: (_____) _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

AUTO INSURANCE INFORMATION

Is this injury related to an auto accident? Yes No If yes please fill out below:

Date of Injury: ____/____/____ In which state did the accident occur? _____

Auto Insurance Name: _____ Name of Insured: _____

Ins. Co. Address: _____ City: _____ State: _____ Zip: _____

Policy #: _____ Claim #: _____

Name of Adjuster: _____ Phone Number: (_____) _____ - _____

WORKERS COMPENSATION

Is this injury related to a workers compensation claim? Yes No If yes please fill out below:

Date of Injury: ____/____/____ Insurance Carrier Name: _____

Name of Adjuster: _____ Claim #: _____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

ATTORNEY INFORMATION

Is there an attorney involved? Yes No If yes please fill out below:

Attorney's Name: _____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

FOOTHILL PHYSICAL THERAPY

FINANCIAL AGREEMENT

Foothill Physical Therapy has adopted the following financial policy in order to better serve you and avoid future misunderstandings regarding our billing and payment policy.

Commercial Insurance Carriers: We bill your insurance carrier as a courtesy to you. You are responsible for all charges that are not covered by your insurance carrier. If an insurance carrier has not paid within 60 days of billing, fees are due and payable in full from you. We require that all co-payments and deductibles be paid prior to services being delivered. If for some reason a payment is made directly to you for services billed by us, you recognize an obligation to promptly remit said payment to Foothill Physical Therapy.

Medicare: Our office is a Medicare participating provider and we bill Medicare for you. We will bill your secondary insurances that automatically crossover through the CSM (Medicare System). If the secondary insurance does not crossover it is the patient's responsibility for filing these claims. As a courtesy we will mail you a claim form that you can then send to your insurance carrier. Any outstanding balances and deductibles are due prior to your appointments. Any co-insurance and non-covered service will be due as service is rendered.

Worker's Compensation: If your visit is work-related we will need the case number and carrier name prior to your visit in order to bill the worker's compensation insurance company.

Methods of Payment:

Our Office accepts the following payment methods:

Cash, Personal Check, Credit Cards and Patient Financing options for those patients who are credit worthy.

For returned checks we assess a \$25.00 NSF charge and report to the local district attorney's office checks that are not paid within 2 weeks of being returned to our office.

I agree that if I choose to make partial payments I will be charged a \$10.00 fee per billing cycle. Balances remaining after 6 months will be forwarded to collections.

I understand and agree that if I fail to make any payments for which I am responsible within 30 days of receipt, I will be responsible for all costs of collecting the monies owed which may include: court costs, attorney fees, and collection agency fees. I hereby authorize Foothill Physical Therapy to release all necessary information to secure the payment of benefits. I further agree that a photocopy of the agreement is as valid as the original.

Appointment Policy:

Foothill Physical Therapy asks that all patients give 24 hours notice for cancellation of appointments. Failure to show for a scheduled appointment time or cancellation without sufficient notice will be subject to a \$45.00 charge.

Authorization for Treatment:

I hereby give consent to authorize all therapy treatments which in conjunction with the judgments of the attending provider may be considered necessary or advisable for the diagnosis or treatment of the above named patient at Foothill Physical Therapy.

Patient Name (Printed): _____

Patient Signature: _____

Date: _____

	Yes	No	Comments		Yes	No	Comments
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Any pins or metal implants	<input type="checkbox"/>	<input type="checkbox"/>	_____
Low blood sugar	<input type="checkbox"/>	<input type="checkbox"/>	_____	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Joint replacement	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Repeated infections	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Difficulty walking	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sensitivity to heat or cold	<input type="checkbox"/>	<input type="checkbox"/>	_____	Joint pain or swelling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of balance	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other: _____			

How many days per week do you drink beer, wine or other alcoholic beverages? _____ None

Do you exercise beyond normal daily activities and chores? Yes No

How many days per week do you exercise? _____ Describe the exercise: _____

Are you wearing: Shoe lifts Inner soles Arch supports Custom arch supports

Please list all of the medications that you are taking:

Please list anything/medication/substance that you may be allergic to: _____

MEDICAL OR REHABILITATIVE SERVICES

Have you had any of the following medical or rehabilitative services for this injury? (Please check all that apply)

	Yes	No		Yes	No		Yes	No
General Practitioner	<input type="checkbox"/>	<input type="checkbox"/>	Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Podiatrist	<input type="checkbox"/>	<input type="checkbox"/>
Orthopedist	<input type="checkbox"/>	<input type="checkbox"/>	Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Chiropractic	<input type="checkbox"/>	<input type="checkbox"/>
Neurologist	<input type="checkbox"/>	<input type="checkbox"/>	Massage Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		

OTHER CLINICAL TESTS

Within the past year have you had any of the following tests? (Please check all that apply)

<input type="checkbox"/> Angiogram	<input type="checkbox"/> EEG (electroencephalogram)	<input type="checkbox"/> Pap smear
<input type="checkbox"/> Arthroscopy	<input type="checkbox"/> EKG (electrocardiogram)	<input type="checkbox"/> Pulmonary function test
<input type="checkbox"/> Biopsy	<input type="checkbox"/> EMG (electromyogram)	<input type="checkbox"/> Spinal tap
<input type="checkbox"/> Blood tests	<input type="checkbox"/> Mammogram	<input type="checkbox"/> Stool test
<input type="checkbox"/> Bone scan	<input type="checkbox"/> MRI	<input type="checkbox"/> Stress test (treadmill or bike)
<input type="checkbox"/> Bronchoscopy	<input type="checkbox"/> Myelogram	<input type="checkbox"/> Ultrasound
<input type="checkbox"/> CT Scan	<input type="checkbox"/> Nerve conduction velocity	<input type="checkbox"/> X Ray

SIGNATURE

I certify that the above information is correct to the best of my knowledge. I will not hold my therapist or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Name (printed): _____

Patient Signature: _____

Date: _____

FOOTHILL PHYSICAL THERAPY

NOTICE OF PRIVACY PRACTICES

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.

Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at Foothill Physical Therapy. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

Our Legal Duty

Law requires us to:

- ◆ Keep your medical information private.
- ◆ Give you this notice describing our legal duties, privacy practices, and your rights regarding this information.
- ◆ Follow the terms of this notice that are now in effect.

We have the right to:

- ◆ Change our privacy practices and the terms of this notice at any time provided that the changes are permitted by law.
- ◆ Make those changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

- ◆ Before we make any important changes in our privacy practices we will change this notice and make the new notice available upon request.

Use and Disclosure of your Medical Information

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed different ways we are permitted to use and disclose medical information. *We will not use or disclose your medical information for any purpose not listed below without your specific authorization. Any specific written authorization you provide may be revoked at any time by contacting us in written form.*

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people taking care of you. We may also share medical information about you to your other health care providers in order to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for our facilities operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting certificates, licenses and credentials needed to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and for use by our facility, we may use and disclose medical information for the following purposes.

Notification: We may use your medical information to notify or to help notify the following: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition or death. If you are present we will get your permission if possible before we share any information, or give you the opportunity to refuse permission. In the case of an emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

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Legal Compliance: We may disclose medical information to comply with applicable law. For example, we may use your medical information to respond to regulatory authorities responsible for oversight of government benefit programs or courts in the course of judicial or administrative proceedings, or to law enforcement officials during an investigation. We may also, as required by law, disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, as well as child abuse and neglect.

Victims of Abuse, Neglect or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or a possible victim of other crimes.

Your Individual Rights

You have the right to:

- ◆ Look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the format request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you \$0.10 for each page as well as postage if you would like the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
 - ◆ Receive a list of all the times we shared your medical information for purposes other than treatment, payment and facility use as well as other specified exceptions.
 - ◆ Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, however, if we do we will abide by our agreement (except in the case of an emergency).
 - ◆ Request that we communicate with you about your medical information by different means or to different locations. Your request must be made in writing to the contact person listed at the end of this notice.
 - ◆ Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information that you want changed. If we accept your request to change the information we will make reasonable efforts to tell others, including people you request, of the change and will continue to use the new information for any future sharing of information.
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Questions and Complaints

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact by phone or in writing:

Kristen Glidewell, MPT
1200 Suncast Lane Suite 5
El Dorado Hills, CA 95762
(916)934-0914

You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint and will not retaliate in any way if you choose to file a complaint. We can also furnish complaint forms to you at no cost.
