

CALDWELL PHYSICAL THERAPY AND SPORTS REHABILITATION  
PATIENT REGISTRATION FORM

Date of First Visit \_\_\_\_\_ Time: \_\_\_\_\_ Date of Injury/Onset/Surgery: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Marital Status: S M D W DL#: \_\_\_\_\_

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Sex: Male Female Type of Accident: Auto Work Other Date of Accident: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_ Email Address: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**If this is for a work related injury ask the following**

Does your employer have an MPN? Yes  No

If yes, are we members of the MPN? Yes  No

If we are not on the MPN whom do we call to get on the MPN?

Referring Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Date of last MD Visit: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Prescription Frequency & Duration: \_\_\_\_\_

In case of emergency: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Have you had PT, OT, Speech, Chiro, Accupuncture this year? \_\_\_\_\_ How many visits? \_\_\_\_\_**

**If this is a Medicare patient ask if they are enrolled in Medicare Home Health? YES NO**

**PRIMARY INSURANCE INFORMATION**

Insurance Carrier: \_\_\_\_\_ Phone #: \_\_\_\_\_

Insured Name: \_\_\_\_\_ ID #: \_\_\_\_\_

Insured Date of Birth: \_\_\_\_\_ Insured Social Security Number: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_ Claim #: \_\_\_\_\_

Is this Plan and Individual or Group Plan: \_\_\_\_\_

Adjustor Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

Insurance Carrier: \_\_\_\_\_ Phone #: \_\_\_\_\_

Insured Name: \_\_\_\_\_ ID #: \_\_\_\_\_

Insured Date of Birth: \_\_\_\_\_ Insured Social Security Number: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_ Claim #: \_\_\_\_\_

Information taken by: \_\_\_\_\_ Date: \_\_\_\_\_

**CALDWELL PHYSICAL THERAPY AND SPORTS REHABILITATION**

**HEALTH QUESTIONNAIRE:**

Have you ever had:	Heart Trouble	Yes	No
	Circulatory Problems	Yes	No
	Diabetes	Yes	No
	Dizzy Spells	Yes	No
	High Blood Pressure	Yes	No
	Vision Trouble	Yes	No
	Impaired Vision	Yes	No

Do you have any metal implanted in your body?                      Yes    No

Are you currently taking any medication?                                      Yes    No

If so, please list below:

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\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

CALDWELL PHYSICAL THERAPY & SPORTS REHABILITATION  
2010 Patient Signature

PATIENT NAME: \_\_\_\_\_

\_\_\_\_\_ Consent for Care and Treatment

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

\_\_\_\_\_ Authorization for Signature on File and Release of Information

I, the undersigned, hereby authorize the office of Caldwell Physical Therapy & Sports Rehabilitation to affix my name to any and all claims or documents as related to any and all health benefits due me. I authorize the release of any information relating to my health care claims. A photostatted 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 Caldwell Physical Therapy & Sports Rehabilitation, and I shall be financially responsible for any unpaid balance. In the event payment is made directly to me for services rendered by this office, I recognize the obligation to promptly remit payment to this office. I hereby authorize and instruct my insurance company to pay by check and mail directly to Caldwell Physical Therapy & Sports Rehabilitation.

\_\_\_\_\_ Financial Responsibility

I, the undersigned, 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 will be subject to a 1.5% finance charge, for which I am personally liable.

\_\_\_\_\_ Cancellation Policy

Specific time is reserved for you when you schedule an appointment. If you cannot keep your scheduled appointment, please give us at least 24 hours notice so that we may reschedule your appointment and offer the reserved time to another patient. There will be a charge of \$50.00 for NO SHOW appointments or cancellations with less than 24-hour notification. I, the undersigned, understand that I will be personally responsible for any cancellation fees.

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

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date

**Caldwell Physical Therapy**  
**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.

***CALDWELL PHYSICAL THERAPY'S LEGAL DUTY***

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

**USES AND DISCLOSURES OF HEALTH INFORMATION**

Caldwell 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, Caldwell 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.

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

In any other situation, Caldwell 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 revoke that authorization to stop future disclosures 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 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. Caldwell 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 COMPLAINS**

If you are concerned that Caldwell 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 Caldwell Physical Therapy's health information practices or if you have a complaint, please contact the following person:

*Caldwell Physical Therapy*  
*Janelle Rivera*  
*1075 Yorba Place, Suite 107, Placentia, CA 92870*  
**Telephone: (714) 524-3500    Fax: (714) 524-0366**

Caldwell Physical Therapy & Sports Rehabilitation

**2010**

**PATIENT INFORMATION ACKNOWLEDGMENT FORM**

I have read and fully understand Caldwell Physical Therapy & Sports Rehabilitation's Notice of Information Practices. I understand that Caldwell Physical Therapy & Sports Rehabilitation 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 Caldwell Physical Therapy & Sports Rehabilitation 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 Caldwell Physical Therapy & Sports Rehabilitation'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 Caldwell Physical Therapy & Sports Rehabilitation 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