Patient Express Registration

bodyworks
PHYSIOTHERAPY
C L I N I C

Today's date:

1. Personal Info

Please Fill-Out Entire Form Completely & Legibly.

Last Name ______ First Name ______ Age ______ ❑ Male ❑ Female

Street Address ______ City ______ State ______ ZIP ______

( ) Home Phone ______ ( ) Cellular ______ Email Address (Important) ______

Emergency Contact Person ______ ( ) Phone # ______ (if minor) Parent/Guardian Name and Signature ______

Occupation ______ Employer Name ______ ( ) Phone # ______

● My condition is related to: ❑ Work ❑ Auto Accident (State______) ❑ Other______

Social Security #______ Date of Birth____/____/____ ❑ Single ❑ Married

Work Status: ❑ Currently Employed: ❑ Retired ❑ Disabled (__Total or __Temporary) ❑ Student (__P/T __F/T)

2. Referral Info

ALL INFO REQUIRED

How did you hear about us? ______

If by a friend or family member, please give their phone number and address below that we may send a thank you note and small gift.

______

______

Primary or Referring Physician Name ______

Street Address ______

City ______ State ______ Zip ______

Phone ______ Fax ______

Email Address ______

Do you have a followup appointment with this physician?______

If yes, when? ______

3. Office Policy

- If you must miss a scheduled appointment, **we require at least 24-hours advance notice**. Failure to advise us that you will miss an appointment will result in a $25 fee. INITIAL HERE: ______
- Being late by more than 10 minutes will require that you reschedule your appointment.
- Co-pays are due upon arrival.
- Cell phones must be shut OFF or silenced.
- Children requiring supervision are NOT allowed to attend sessions with you.
- We are unable to see you if you are receiving ANY Home Health Services.

4. Insurance Assignment

I agree to a direct assignment of my rights and insurance benefits (as per our *Insurance Worksheet* form). Any payment by my insurance company will not exceed my indebtedness and I agree to pay any balance of professional charges over and above any insurance payment.

❑ I have read and agree to all the policies on this form. Signed______

Physical Therapy Pre-Exam Questionnaire

In order to evaluate your condition fully, please be as accurate as possible. Thank you.

1. **What is your age?** ______
2. **What is your gender?** ▯ Male ▯ Female ▯ ______
3. **What is your occupation?** ____________________
   - Are you working now? ▯ Yes ▯ No
4. **Have you had physical therapy before?** ▯ Yes ▯ No
5. **Where is your pain/problem?** ____________________
6. **What caused your pain/or problem?** ____________________
7. **Approximately when did it start?** ____/____/20_____
8. **Is it getting worse, better, or staying the same?** ____________________
9. **Have you ever had this pain/problem before?** ▯ Yes ▯ No

   ____

10. **Is your pain constant (never goes away)?** ▯ Yes ▯ No
11. **On the scale below circle your worst pain level in the past couple of days:**

    Mild *Moderate* *Severe*
    0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10

12. **Are you taking any medication for this pain/problem?** ▯ Yes ▯ No
    - If yes, what and does it help? ____________________ ▯ Yes ▯ No
13. **Are any of your usual everyday activities affected?** ▯ Yes ▯ No
    - If yes, describe how.

    ____

14. **List all past surgeries with dates:**
15. **List all medical conditions you have (or were told you have):**
16. **Are you currently receiving ANY Home Health Services?** ▯ Yes ▯ No

Patient Name: ______________________________________

Signature: ______________________________________ Date: __________

Initial Evaluation Part 1 **Physical Therapist Initials** ______

Statement of Privacy Notice

Effective June 1, 2003

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.

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

We may contact you by phone, mail, or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by us.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at **(760) 327-4244**. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer by calling this office at **(760) 327-4244**. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide the company above with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

____

Patient's Name (print)

____

Patient's Signature   Date

____

Authorized Facility Signature   Date

bodyworks
PHYSIOTHERAPY
CLINIC

PATIENT AGREEMENT

Patient Responsibilities

- You are responsible to provide us with accurate billing information at the time of service.
- If your insurance company requires you to choose a primary care provider (PCP). It is your responsibility prior to your visit to ensure that you have authorization for your visit with us.
- Our billing staff is available to provide you with assistance but cannot resolve disputes between you and your insurance company. ____ **Patient initials**

Copayments and deductibles

- Your insurance company requires you to pay your copay at the time of each visit.
- If you do not have active insurance coverage, you will be expected to pay at the time of your visit.
- It is your responsibility to understand any deductibles and co-insurance that may apply to you under your Insurance Policy.
- Our billing department will send you a statement of the amount your insurance company has determined is applied to your deductible and/or co-insurance and is owed by you.

____ **Patient initials**

Insurance Information

- Medical insurance does not always cover the entire cost of your medical care. If we believe a service we offer is not covered by your insurance coverage, we will tell you. In some instances, however we do not learn that a service is not covered until after we submit a bill. You are responsible for payment if your insurance company refuses to pay for a service.

____ Patient initials

Late, Cancellation and No show Policy

If a patient presents to the office 10 minutes late for a scheduled appointment with our providers, the patient will be asked to reschedule their appointment due to the Late Arrival Policy. When a patient arrives late, the time spent with the patient is minimized and does not allow for a full assessment. It also disrupts the schedules of our providers and other patients.

____ **Patient initials**

Assignment and Release

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Bodyworks Physiotherapy Clinic to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Recent changes in insurance regulations shorten the time frame for claim submissions. I agree to pay any out of pocket expenses in full to Bodyworks Physiotherapy Clinic within thirty days from today's date for uncovered or denied services by my presented insurance coverage.

____ **Patient initials**

SIGNATURE______________________________ **DATE**______________