



Performance-Driven Physical Therapy & Fitness

Patient Registration Form

Date:

Primary Insurance: Medicare <input type="checkbox"/> Group Health <input type="checkbox"/> Workers Comp <input type="checkbox"/> Lien <input type="checkbox"/> Other <input type="checkbox"/>			Secondary Insurance: Medicare <input type="checkbox"/> Group Health <input type="checkbox"/> Workers Comp <input type="checkbox"/> Lien <input type="checkbox"/> Other <input type="checkbox"/>		
<input type="checkbox"/> New Patient <input type="checkbox"/> Re-Start <input type="checkbox"/> New Diagnosis <input type="checkbox"/> New Insurance			PTPN <input type="checkbox"/> Yes <input type="checkbox"/> No		
Patient #	Title	Patient Name (Last, First, Middle Initial)			
Address			City/State/Zip		
Home Phone ()		Work Phone ()		Email Address	
Social Security #	DOB	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Driver's License #	Financial Class	
Referring Physician		UPIN	Treating Therapist		
Patient Status <input type="checkbox"/> Active <input type="checkbox"/> SFA	Primary location The Physical Edge	Martial Status	Student	Employment Status	
Occupation		Employer			
Address			City/State/Zip		

Emergency Contact (Name)	Home Phone ()	Work Phone ()
Address	City/State/Zip	Relationship to Patient

Financially Responsible Party Other than Patient

Name (First, Middle Initial, Last)		Relationship to Patient	
Address		City/State/Zip	
Home Phone ()	Work Phone ()	Email Address	
Social Security #	DOB	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Driver's License #

Injury Information

Is condition surgery related? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Surgery	Surgical Procedure
Is condition accident related? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was an automobile involved? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Accident
Describe Accident		
Were you injured on the job? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Injury	Are you currently working? <input type="checkbox"/> Yes <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> No
Name of employer at time of accident		City, State, Zip Code
Describe Injury		
Is litigation involved? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Attorney	Phone # ()



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Insurance Information

Were benefits and authorization verified? Yes No

Primary Insurance		In- network <input type="checkbox"/>	Out-of-network <input type="checkbox"/>	Pre-Certification <input type="checkbox"/> Yes <input type="checkbox"/> No		Visits per Year
Claims Mailing Address			City, State, Zip Code			
Subscriber Name		Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to Patient		
ID Card #(including alpha prefix)		Group #		Authorization #		
Claim #	Effective Date	Coverage%	Co-Ins%	Co-Pay by Specialty \$	Visits Remaining	
Deductible Start Amount \$	Deductible Remaining Amount \$		Pre-Certification Phone # ()			
Benefits Verified By	Date	Spoke to		Ins. Customer Service Phone # ()		

Secondary Insurance		In- network <input type="checkbox"/>	Out-of-network <input type="checkbox"/>			
Claims Mailing Address		City, State, Zip Code				
Subscriber Name		Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to Patient		
ID Card #(including alpha prefix)		Group #		Authorization #		
Claim #	Effective Date	Coverage%	Co-Ins%	Co-Pay \$	Pre-Certification <input type="checkbox"/> Yes <input type="checkbox"/> No	Visits per Year
Deductible Start Amount \$	Deductible Remaining Amount \$		Pre-Certification Phone # ()			
Benefits Verified By	Date	Spoke to		Ins. Customer Service Phone # ()		

The above description is a quote of your insurance(s) benefits. We assume no liability for any errors made by your insurance carrier(s) in this quotation. It is your responsibility to clarify any discrepancies in eligibility, benefits and/or authorization and inform our clinic immediately. We have reviewed these benefits with you. You understand and agree to pay any balance remaining after your insurance carrier(s) has paid its portion of the charges.

Patient Initials	Date	Front Office	Date

ASSIGNMENT OF INSURANCE BENEFITS

1. The undersigned agrees, whether signing as agent or patient, and it hereby individually obligated to pay for services rendered to the patient in accordance with the regular rates and terms of the company, which are not reimbursed by third parties. The undersigned further agrees to bear legal fees and collection expenses, which may be incurred by the company, in collection of payment on the amount, if that amount becomes delinquent.
2. The undersigned hereby authorizes treatment by *The Physical Edge* and assigns to *The Physical Edge* any and all benefits arising out of any type of insurance, which insures the patient's bill. The undersigned understands that the temporary acceptance of verified insurance coverage in lieu of payment does not release the patient from ultimate payment responsibilities.
3. The undersigned hereby authorizes *The Physical Edge* to release any or all information to third parties, including but not limited to employers and insurance companies, who may be liable to the patient or *The Physical Edge* for payment of charges to the patient.
4. *The Physical Edge* reserves the right to modify the privacy practices outlined in the notice. The undersigned acknowledges having received a copy of the Notice of Privacy Practices for *The Physical Edge*

Patient Signature:	Date:
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MEDICAL HISTORY

Do you have/or have you had any of the following:

Problem			Date of Onset	Medications taken for problem
High Blood Pressure	Yes	No		
Heart Disease	Yes	No		
Heart Attack	Yes	No		
Pacemaker	Yes	No		
Cardiac Surgery	Yes	No		
Diabetes	Yes	No		
Cancer Type _____	Yes	No		
Neurological Disorder Type _____	Yes	No		
Headaches/Migraines	Yes	No		
Asthma/Respiratory Problems	Yes	No		
Dizziness/vertigo	Yes	No		
Incontinence: urinary or bowel	Yes	No		
Nervous/Psychological Disorder Type _____	Yes	No		
Arthritis: Osteo Rheumatoid	Yes	No		
Osteoporosis	Yes	No		
Other: _____ _____				

Please enter the date of injury for what you are being seen for today: _____

Surgeries: _____ Date _____ Date _____ Date _____

Allergies: _____

Hearing problems: Yes No VISION PROBLEMS: YES NO Are you/could you be pregnant? Yes No

Metal Implants: Yes No Area(s) _____

Patient Name: _____ Date: _____

APPOINTMENT and PAYMENT AGREEMENT

Patients are seen by appointment only. We make every effort to be on time for our patients and ask that you extend the same courtesy to us. If you cannot keep an appointment, please notify our office immediately.

This courtesy on your part makes it possible to give an appointment to another person who needs treatment.

We reserve the right to charge \$25 for appointments broken or cancelled without 24 hour notice.
_____ (please initial)

Co-payments and Co-insurance are due at the time of the service.

Repeated tardiness or not showing for scheduled appointments will result in your future appointments being cancelled (if you are a workers comp patient, your case manager and physician will be notified).

We appreciate patients arriving early for appointments; however, arriving early does not ensure you will be seen before your scheduled appointment time.

Thank you for your cooperation!

The Physical Edge

Patient Signature

Date

The Physical Edge
253 N. Santa Anita, Arcadia, CA 91006
626-294-007, Fax: 626-294-0080

CONSENT FOR TREATMENT

Consent for Physical Therapy: *Knowing that I am suffering from a condition requiring diagnostic or medical treatment, I hereby consent to care by The Physical Edge thereafter to be known in this document as "Clinic", as they may deem necessary by their judgment, under the prescription of a licensed physician. I do hereby voluntarily consent to the rendering of care for a condition requiring physical therapy services. I understand and expect that the care I receive by Clinic will meet customary standards, I do understand that medicine is not an exact science and acknowledge that diagnosis and treatment may involve risks of injury. I acknowledge that no guarantees have been made to me as a result of examination of treatment. I hereby authorize The Physical Edge to retain any records for use, for research and for teaching purposes. I understand that The Physical Edge is a teaching clinic for physical therapy graduate students. I also understand that there will be instances when a student will perform my evaluation or my treatment under the direction and guidance of the attending physical therapist. If I would prefer to not be treated by a student I know that it is my right to inform my treating physical therapist.*

If I refuse treatment that is suggested for me, I will not hold The Physical Edge or any individual responsible for any consequences resulting from my decision.

*I, _____, have had full opportunity to read and consider the contents of this **Consent for Treatment**. I understand that, by signing this Consent form, I am giving my consent to treatment and attest that I am aware and understand all of the above.*

Signature: _____

Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's
Name:

Relationship to Patient:



Notifier(s): The Physical Edge

Patient Name: _____

A_DVANCE **B**_ENEFICIARY **N**_OTICE OF **N**_ONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for *Physical Therapy*, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the *Physical Therapy*.

<i>Physical Therapy Services</i>	(E) Reason Medicare May Not Pay:	(F) Estimated Cost:
	Benefits are not covered above \$1870 of total billed amount per calendar year. This is for combined therapy services of physical and speech therapy.	

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- **Ask us any questions that you may have after you finish reading.**
- **Choose an option below about whether to receive the *physical therapy* listed above.**
 Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

<p>(G) OPTIONS: Check only one box. We cannot choose a box for you.</p> <p><input type="checkbox"/> OPTION 1. I want the <i>physical therapy</i> listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.</p> <p><input type="checkbox"/> OPTION 2. I want the <i>physical therapy</i> listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.</p> <p><input type="checkbox"/> OPTION 3. I don't want the <i>physical therapy</i> listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.</p>
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Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

Signature: _____	Date: _____
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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

The Physical Edge Physical Therapy, Inc

dba The Physical Edge

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.

THE PHYSICAL EDGE'S LEGAL DUTY

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

USES AND DISCLOSURES OF HEALTH INFORMATION

The Physical Edge 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, The Physical Edge 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.

The Physical Edge may also use or disclose your personal health information without 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, The Physical Edge'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 later revoke that authorization to stop future disclosures at any time.

The Physical Edge may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of 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. 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 where 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 circumstances. The Physical Edge will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

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

The Physical Edge
Office Administrator