

Professional Physical Therapy
26471 Crown Valley Parkway, Suite 200
Mission Viejo, California 92691

PATIENT REGISTRATION

Date _____

Physician _____ Diagnosis _____

Last Name _____ First Name _____

Middle _____ Nickname _____

Address _____

City _____ State _____ Zip _____

Social Security Number _____

PLEASE CHECK ONE OF THE FOLLOWING CONTACT BOXES IF YOU WOULD LIKE TO RECEIVE APPOINTMENT REMINDERS

Home Phone _____ Cell Phone _____ pice xt

Email _____

Age _____ Date of Birth _____ Sex _____ Date of Onset _____

IS THIS A WORK RELATED INJURY? YES NO

Employer _____ Work Phone _____ Employer Address _____

How Did You Hear About Us? Doctor Friend 24Hr Fitness Online Other _____

1. Treatment Authorization & Release of Information: I authorize treatment by Professional Physical Therapy. I authorize payment of medical benefits directly to Professional Physical Therapy for services rendered to me. I understand that I am solely responsible for all charges (unless this treatment is for an accepted workers compensation claim). I will make sure that my portions of all claims are paid promptly and all co-pays are paid at the time of service. I also authorize Professional Physical Therapy to furnish information to my insurance carriers and referring physicians concerning this treatment.

Patient or Guardian Signature _____ Date _____

2. Cancellation Policy: I understand any cancellations that are not made 24 hours prior to my scheduled appointment time are subject to a \$25 fee. This fee will be billed to my account.

Patient or Guardian Signature _____ Date _____

Professional Physical Therapy
 26471 Crown Valley Parkway, Suite 200
 Mission Viejo, California 92691-6302

MEDICAL HISTORY

NAME: _____ Date: _____
 Home Phone: _____ Work Phone: _____
 Primary (Family) Doctor: _____ Phone # _____

MEDICAL HISTORY - *Please circle any of the following that apply to you.*

- | | | | |
|-------------|---------------------|----------------|--------------------|
| Heart | Diabetes | Metal Implants | Osteoporosis |
| Smoking | Pacemaker | Kidney | Bladder Control |
| Lung | Currently Pregnant | Seizures | Gastro Intestinal |
| Cancer | High Blood Pressure | Anemia | Leg/Ankle Swelling |
| Other _____ | | | |

MEDICATIONS: *Please list any medications that you are currently taking or have recently used.*

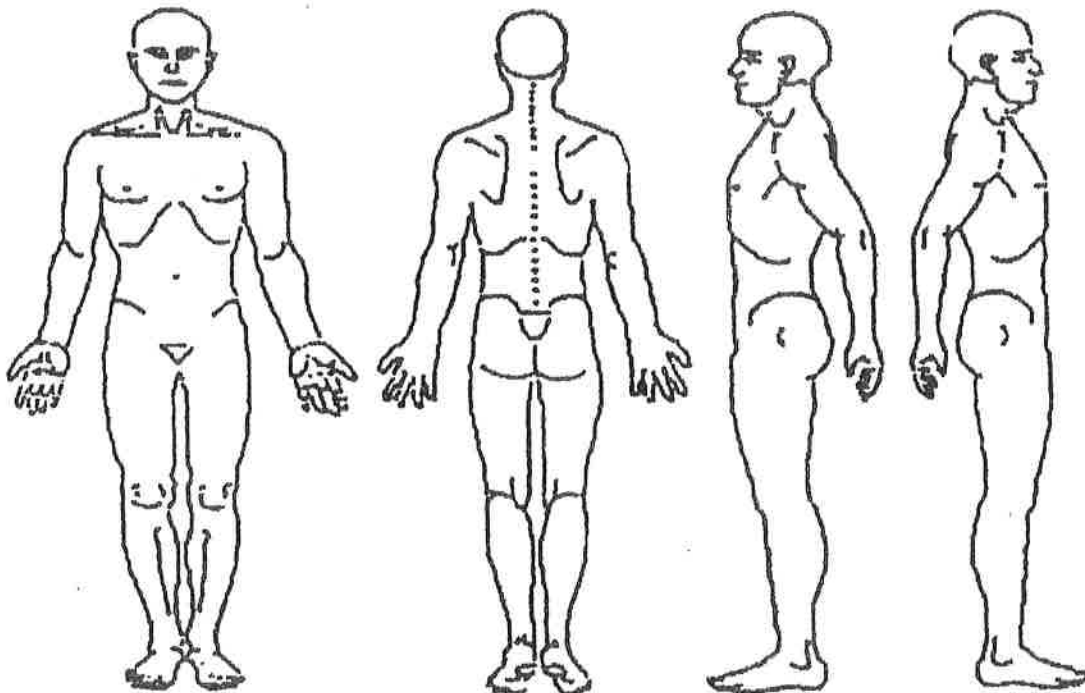
ALLERGIES Please list any known allergies: _____

Using this diagram, please circle your pain level: 0-No Pain 10-Severe Pain

(0 1 2 3 4 5 6 7 8 9 10)

Please write the letter by the body part that pertains to your symptoms:

S-sharp/stabbing pain, D-dull/aching pain, ST-stiffness, T-tingling/pins or needles, N-numbness/no sensation.



EMERGENCY NOTIFICATION:

NAME _____ RELATIONSHIP _____ PHONE # _____
 NAME _____ RELATIONSHIP _____ PHONE # _____

To the best of my knowledge, all the information that I have provided is true and correct.

Signature: _____

Richards Physical Therapy, Inc.

NOTICE OF PRIVACY PRACTICES

This notice describes how information about you as a patient of this practice, Richards Physical Therapy, Inc., may be used and disclosed, and how to access your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

The following circumstances may require us to use or disclose your health information:

1. **To provide treatment:** We will use your health information within our office to provide you with the best health care possible. This may include administrative and clinical office procedures to schedule and coordinate care between physician, technician, nurse and business office staff. Richards Physical Therapy, Inc. will report to your prescribing physician and your insurance company.
2. **To obtain payment:** We may include your health information with an invoice used to collect payment for treatment you received in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will make every attempt to work only with the companies with similar commitment to the security of your health information.
3. **To conduct health care operation:** Your health information may be used during performance evaluations of our staff, during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes or certification, licensing or credentialing activities.
4. **Communications:** Because we believe regular follow up is very important to your health, we may remind you of a scheduled appointment or to contact us to schedule an appointment. These communications may include telephone, text or email reminders. We may share your health information with those you tell us will be helping you with your home treatment, medications, or payment. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may request that we contact you at home, rather than work. We will try to accommodate reasonable requests.
5. **Required by law:** We may disclose your health information to public health oversight agencies that are authorized by law to collect information, when required to do so by a law enforcement official, lawsuits and similar proceeding in response to a court or administrative order, when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public, for Worker's Compensation and similar programs.

Our patient medical records are kept confidential, secure, and out of reach by unauthorized persons. A written release signed and dated by the patient/guardian must be obtained prior to the release of medical record information, except for Initial Evaluations, Progress Notes, Plan of Care, Daily Notes and Re-Examinations .

You are entitled to receive a copy of this Notice of Privacy Practices.

I _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of protected health information to carry out treatment, payment activities, and health care operations as described in the Privacy Notice.

Signature: _____ Date _____
(Parent/guardian if patient is a minor)

HOW IS YOUR BALANCE? NAME _____ DATE _____

Falls Efficacy Scale

6/18/13 11:54 AM

Falls Efficacy Scale

Take a bath or shower

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Reach into cabinets or closets

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Walk around the house

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Prepare meals not requiring carrying heavy or hot objects

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Get in and out of bed

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Answer the door or telephone

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Get in and out of a chair

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Getting dressed and undressed

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Personal grooming (i.e. washing your face)

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Getting on and off of the toilet

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

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