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

Date ____________________

PATIENT REGISTRATION

Physician ______________________________________ Diagnosis ____

Last Name _____________________________________ First Name ____

Middle ____ Nickname ____

Address ____

City ____ State ___________ Zip _______________

Social Security Number ____

Home Phone ______________________________ Cell Phone __________________

PLEASE GIVE US YOUR E-MAIL IF YOU WOULD LIKE TO RECEIVE APPOINTMENT REMINDERS

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**___________________________

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1. **<u>Treatment Authorization & Release of Information</u>: 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. **<u>Cancellation Policy & No Shows</u>: I understand any cancellations that are not made 24 hours prior to my scheduled appointment time or no shows are subject to a $75 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.***

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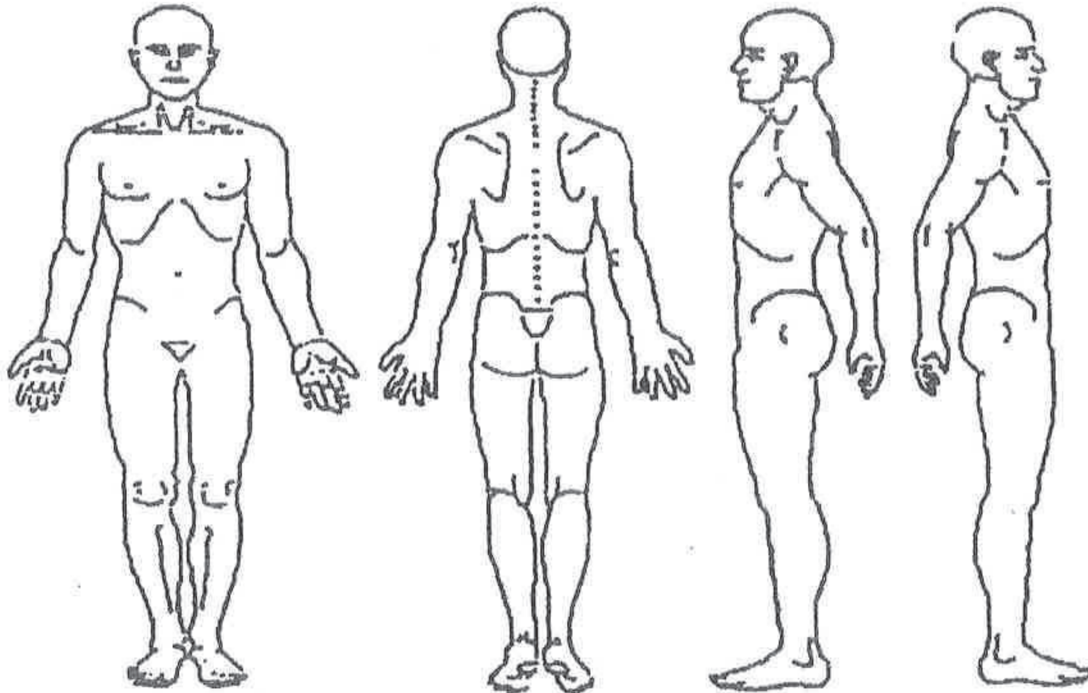
ALLERGIES Please list any known allergies: ______________________________

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)