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

IS THIS A RESULT OF A MOTOTR VEHICLE ACCIDENT? ☐ YES ☐ NO

ARE YOU CURRENTLY HAVING HOME HEALTH? ☐ YES ☐ NO

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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 & No Shows:** 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, CA 92691-6302

MEDCIAL HISTORY

Name: ______________________________ Date: ______________

Primary Care Doctor: ______________________________ Phone: ______________

Medical History- *Please circle all 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: ____

Height ____________ Weight ____________ Have you had a fall in the last year? Yes No (Circle one)

MEDICATIONS: Please list all medications with dosage/frequency that you are currently taking

____

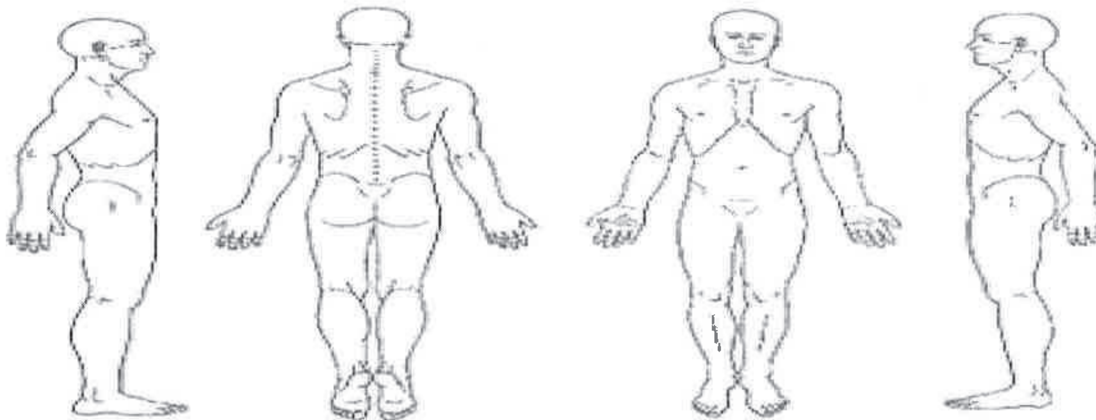
Allergies: (Please list any know allergies) ____

Using the diagram below, 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, D-dull/aching, ST-stiffness, T- tingling/pins or needles, N-numbness/no sensation



EMERGENCY NOTIFCIATON:

NAME______________________ RELATIONSHIP______________ PHONE#______________

NAME______________________ RELATIONSHIP______________ PHONE#______________

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

Signature: ______________________________________

Professional Physical Therapy

NOTICE OF PRIVACY PRACTICES

This notice describes how information about you as a patient of this practice, Professional Physical Therapy, 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 1995 (HIPPA).

Our practice is dedicated to maintaining the privacy of your health information, 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 the best health care possible. This may include administrative and clinical office procedures to schedule and coordinate care between physician, nurse, and business office staff. Professional Physical Therapy will report to your prescribing physician and health insurance company.
2. **To obtain payment**: We may include your health information with invoice used to collect payment for treatment you received in our office. We may do this with insurance forms in the mail or sent electronically.
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 agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the process or certification, licensing, or credentialing activities.
4. **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 the safety of your, another individual, or public, or Worker's Compensation and similar programs.
5. **Communications**: We believe follow up is important to your health, we may remind you of scheduled appointment or contact us to schedule an appointment. These communications may include telephone, text, or email reminders. We may share your health information with those you authorize are helping you with home treatment, medications, or payment. Please list any persons you would like to have access to your billing, appointment, or health information, such as your spouse, caretaker, or other family member.

______________________	______________	______________________	______________
Name	Relationship	Name	Relationship

Our patient records are kept secure. A written release signed and dated by the patient/guardian must be obtained prior to the release of medical record information.

You are entitled to this notice of Privacy Policies.

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 disclose 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)