NEW PATIENT REGISTRATION RECORD

PATIENT INFORMATION

Patient Name:_____

Address:_____

City:_____

State:_____Zip:_____

Home phone:_____

Work phone:_____

Cell phone:_____

Date of Birth:_____ Age:___ Sex: M__ F__

Patient's SSN:_____

Occupation:_____

Place of employment:_____

Is patient a student, minor or have a caretaker?

Yes _____ No____

Parent/Guardian/Caretaker name:

_____

Address and Phone if different than Patient:

_____

School:_____City:_____

Emergency contact person and phone #:_____

Email:_____

How did you hear about us? _____

Would you like to receive billing statements via email? Y/N

INJURY INFORMATION

Date of Injury: _____ Work related? Yes____No____ Auto accident? Yes____ No____

Other Cause: _____

REFERRAL INFORMATION

Referring Physician's Name:

_____

Have you been seen here before? Yes____No____

If yes, when? _____

INSURANCE INFORMATION

Primary Insurance Information:

Name of Insurance Co.:_____

Policy ID#:_____

Group#:_____

Patient relationship to subscriber:

Self Spouse Child Other

Subscriber information(if not patient):

Name:_____

SSN:_____

DOB:_____

Employer:_____

Secondary Insurance Information:

Name of Insurance Co:_____

Policy ID#:_____

Group#:_____

Patient relationship to subscriber:

Self Spouse Child Other

Subscriber's information(if not patient):

Name:_____

SSN:_____

DOB:_____

Employer:_____

I, the undersigned, assign directly to Tice Valley Physical Therapy all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Tice Valley Physical Therapy to release all information necessary to secure payment for benefits.

X_____

Signature (Parent/Guardian if Patient is a minor) Relationship to Patient Date

HEALTH HISTORY QUESTIONNAIRE

Please answer the following questions as accurately as possible:

1. Do you have any physical limitations? ☐ Yes ☐ No
   Explain: _____

2. Do you have or have you had any neck, back, or extremity injuries or strains? ☐ Yes ☐ No
   Explain: _____

3. Do you have or have you had any heart, vascular, blood pressure, cholesterol, or triglyceride problems? ☐ Yes ☐ No
   Explain: _____

4. Do you have asthma or other bronchial / pulmonary / respiratory conditions? ☐ Yes ☐ No
   Explain: _____

5. Are you diabetic or hypoglycemic? ☐ Yes ☐ No
   Explain: _____

6. Have you had any surgery within the past two years? ☐ Yes ☐ No
   Explain: _____

7. Have you been to physical therapy before? ☐ Yes ☐ No
   Explain: _____

8. Do you smoke? ☐ Yes ☐ No

9. Are you taking any medications? ☐ Yes ☐ No
   If yes, please list all medications and dosages:

_____

_____

_____

10. Do you have any conditions not listed? ☐ Yes ☐ No
    If yes, please list: _____

_____ _____

Signature Date

INSURANCE DISCLAIMER

Tice Valley Physical Therapy of Walnut Creek bills all charges for services to the insurance company you have specified as being your carrier on your behalf, whether or not we are contracted with that carrier.

Tice Valley Physical Therapy of Walnut Creek does not assume any responsibility for verifying:

- Your coverage or limits of coverage
- The amount, if any, of your co-payment for physical therapy
- The amount that will be paid by your insurance company
- If you have met your deductible or not
- Whether your insurance plan allows you to go to non-participating providers

PLEASE NOTE: If this is a workers compensation claim, your worker's compensation billing information, adjuster's name, and your worker's compensation claim number is required or your will be personally responsible for payment.

I understand that Tice Valley Physical Therapy will charge to my account 6% penalty per month on any unpaid balance.

The burden of proof lies within the recipient of the service, or in the case of a minor child, the parent or guardian.

In the case of contracted insurance companies, even though we contract with your insurance company, it does not relieve you from responsibility of all sums due.

IT IS STRONGLY RECOMMENDED that you consult your insurance handbook, or call the telephone number on your insurance card for benefit information to make sure that you are using the proper facility and for verification of benefits.

CO-PAYMENTS/CO-INSURANCE: If you have a co-payment/co-insurance, it is due at the time of service.

It has been determined that your co-payment/co-insurance is _____

I have read and understand the foregoing and agree to abide by the provisions of this disclaimer

_____
Patient/Guardian

_____
Date

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.

Tice Valley Physical Therapy, Inc. LEGAL DUTY

Tice Valley Physical Therapy, Inc. 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

Tice Valley Physical Therapy, Inc. 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, Tice Valley Physical Therapy, Inc. 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.

Tice Valley Physical Therapy, Inc. 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, Tice Valley Physical Therapy, Inc.'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.

Tice Valley Physical Therapy, Inc. 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. Tice Valley Physical Therapy, Inc. 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 Tice Valley Physical Therapy, Inc. 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 Tice Valley Physical Therapy, Inc.'s health information practices or if you have a complaint, please contact the following person:

Tice Valley Physical Therapy, Inc.
Amy Blankenship
1848 Tice Valley Blvd. Walnut Creek, CA 94595
Telephone: 925-935-0510 Fax: 925-935-0750

TICE VALLEY PHYSICAL THERAPY, INC.

PATIENT INFORMATION CONSENT FORM

I have read and fully understand Tice Valley Physical Therapy, Inc.'s Notice of Information Practices. I understand that Tice Valley Physical Therapy, Inc.'s may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operation related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Tice Valley Physical Therapy, Inc. will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Tice Valley Physical Therapy, Inc.'s Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____

Patient Name

_____

Signature

_____

Date

TICE VALLEY PHYSICAL THERAPY INC.

CANCELLATION AND MISSED APPOINTMENT POLICY

At Tice Valley Physical Therapy, we are committed to providing you with excellent service. As a part of this service, we reserve specific appointments for you with your physical therapist. We understand that appointments may need to be changed and/or canceled from time to time. In the event you need to cancel an appointment we request that a minimum 24 hour notice be given so that we can offer that appointment to other patients.

A service fee of $40.00 will be charged for appointments missed without proper notice. We realize that situations beyond your control do exist such as illness, public transportation problems, and family emergencies. These cancellations are excluded from this policy.

I HAVE READ THE ABOVE CANCELLATION AND MISSED APPOINTMENT POLICY AND AGREE TO THE TERMS OF THIS POLICY.

_____
Date

_____
Print Name

_____
Signature

_____
Parent/ Guardian

Pain Disability Index

(Medicare Required)

-Pain Disability Index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.

-For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family/Home Responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school).
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Recreation: This disability includes hobbies, sports, and other similar leisure time activities.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Social Activity: This category refers to activities, which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Occupation: This category refers to activities that are part of or directly related to one's job.This includes non-paying jobs as well, such as that of a housewife or volunteer.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Sexual Behavior: This category refers to the frequency and quality of one's sex life.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Self Care: This category includes activities, which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed, etc.)
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Life-Support Activities: This category refers to basic life supporting behaviors such as eating, sleeping and breathing.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

***Have you had Home Health Care Services within the past 3 months?** Y / N (circle) If Yes, Date of Discharge: _____

***Have you fallen in the past 12 months?** Y / N (circle)

If Yes, how many times? _____

Height: _____ Weight:_____

Signature_____ **Please Print**_____

Date _____