MedStar PHYSICAL THERAPY

REGISTRATION FORM

[PLEASE PRINT]

	Dr:

PATIENT INFORMATION

Patient's Last Name : First : Middle:	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital Status : Single ☐ Married ☐ Disvorced ☐ Separated ☐ Widowed ☐ Partner ☐		
Is this your legal name ? Yes ☐ No ☐	If Not, What is your legal name ?	Birth date :	Age:	Social Security Number : Sex : ☐ M ☐ F
Preferred Language :	Race :	Ethnicity :		
Street address :	Cell phone :	Home phone :		
City :	State:	ZIP Code:	Driver's License:	Email Address:
Occupation :	Employer & Employer Address :	Employer phone :		

Who referred you this office ? (please check one box): Referred by Doctor – Dr.'s Name :

☐ Family –Name : ☐ Friend – Name : ☐ Internet ☐ Hospital – Name :

How would you like us to contact you for appointment reminder : ☐ Home Page ☐ Cell Phone

PHARMACY : Name, Address, and phone number of pharmacy you like medication called in to:

INSURANCE INFORMATION

(Please give your insurance card to the front desk.)

Person responsibie for bill:	Birth date :	Address (if different):	Home Phone :

Is this person a patient here : ☐ Yes ☐ No Is this injury : ☐ Work Related ☐ Auto ☐ Personal Injory

Is this patient covered by insurance ? ☐ Yes ☐ No

Please incicate primary insurance	☐ Blue Cross	☐ Blue Shield	☐ Atena	☐ Cigna	☐ Healthnet
☐ SAG	☐ PacifiCare		☐ Medicare / Medi-Cal	☐ Other	

Subscriber's S.S number :	Subscriber's name :	Birth date :	Group number:	Policy number :	Co-payment:

Patient's relationship to subscriber : ☐ Self ☐ Spouse ☐ Child ☐ Other :

IN CASE OF EMERGENCY

Name of local friend or relative :	Relationship to patient :	Home phone :	Work phone :

The above information is true to the best of my knowledge. I authorize my insurance benefist be paid directly to the physician. I understand that I am financially responsible for any balance.

Patient / Guarcian signature Date

HISTORY FORM – NEW PATIENT

PATIENT NAME : _____ TODAY'S DATE. _____

Who referred you to this office ? _____ internist|Family MD : _____

CHIEF COMPLAINT

1) What is the main reason for you visit today ? _____ Right/Left/Both _____

HISTORY OF PRESENT ILLNESS

Age _____ Height _____ weight _____ Right/Left Handed _____ Occupation _____

1) What was the date your symptoms started/were injured ? _____

2) Explain Injury: _____

3) Was this a work related accident ? ☐ Yes ☐ No
   If yes , are you still working ? ☐ Yes ☐ No
   If yes, are you working : ☐ Full ☐ Light duty

4) Was this an auto accident ? ☐ Yes ☐ No
   If so, were you driving ? ☐ Yes ☐ No
   Did airbags inflate ? ☐ Yes ☐ No

5) Recreational or athletic injury ? ☐ Yes ☐ No
6) Accident in your home ? ☐ Yes ☐ No

7) On s scale of 1 (least) to 10 (greatest),what level is your pain today ? 1 2 3 4 5 6 7 8 9 10

8) Describe symptoms you are havng (check all that apply):

☐ Aching	☐ Gives way	☐ Sharp	☐ Stabbing	☐ Wakes you up
☐ Clicking	☐ Locking	☐ Snapping	☐ Throbbing	☐ Weakness
☐ Dull	☐ Numbness	☐ Sore	☐ Tingling	

9) How long does problem last ? ☐ Constant ☐ Cornes and goes ☐ Other
10) Does anything make it butter ? ☐ Yes ☐ No Explain : _____

11) Does anything make it worse ? ☐ Yes ☐ No Explain : _____

12) Does it radiate anywhere ? ☐ Yes ☐ No Explain : _____

13) List any other doctors you have seen for this problem : _____

_____

_____

_____

14) List any previous tests, procedures, treatments (injections, physical therapy, medications) for this problem:
   Physical Therapy : _____ # of visits per week _____ weeks/months _____
   Injections : How many ? _____ Date of last injection ___/___/__ Type of injection _____
   Medications you have tried : _____
   Chiropractic /Acupuncture : _____ #of visits

MEDICATIONS

Are you sensitive or allergic to any medications ? ☐ Yes ☐ No

If yess , please mark all that apply : ☐ Penicillin ☐ Keflex ☐ Aspirin ☐ Codeine ☐ Tetracycline
☐ Erythromycn ☐ Valium ☐ Demerol ☐ Barbituates ☐ Epinephrine
☐ Lodine ☐ Latex ☐ Naproxen ☐ Other

Are You currently taking :
Any cortisone-type medication (e.g. Prednisone) ? ☐ Yes ☐ No
Any blod thinning medication (e.g. Coumadin, Warfarin, ASA, Plavix, etc) ? ☐ Yes ☐ No
Family member ever had major adverse reaction to anesthesia ? ☐ Yes ☐ No
If Yes, Explain _____

Please list all the medications you are currently taking and the dosages : _____

PAST MEDICAL HISTORY

Serious Childhood lllnesses : _____
Adult lllnesses : List and document hospital stays if any _____

Surgeries : List date, procedure, surgeon, and hospital _____

Major accidents/Injories with dates : _____

FAMILY HISTORY

Father: Age if alive _____ Age /death and cause _____
Mother : Age if alive _____ Age /death and cause _____
Siblings : Age / health status _____
Children : Age / health status _____
Family Disease: (Hypertension, Diabetes, Tuberculosis, Goul, Cancer, etc) _____

SOCIAL HISTORY

Do you smoke ? Yes No If yes, how much ? _____ How long ? _____

If no, did you never smoke ? Yes No If yes, how much ? _____ How long ? _____ Year quit _____

Do you drink alcohol ? Yes No If yes, How much ? _____ How often ? _____

Do you take any drugs ? Yes No If yes, what drugs ? _____
How often ? _____
Have you deen or are you addicted ? _____ Detoxed ? _____

REVIEW OF SYSTEMS

Please circle those that apply or check the " none " box

GENERAL
Fever, Night Sweats
Marked Weight gain/loss
None ☐

HEAD, EYES, EARS, NONE
Ferquent headaches
Neck pain / stiffness
Glaucoma
Blurring problems
Dizziness
Hearing problems
Sinus problems
None ☐

CHEST/RESPIRATORY
Asthma
Sputum production from cough
Cough up blood
Chronic cough
Positive TB skin test
Abnormal Chest X-ray
None ☐

CARDIAC
High Blood Pressures
History of Heart attack
Chest Pain
Rapid/Abnormal Pulse
Ankle Swelling
None ☐

VASCULAR
Previous phlebitis
Leg cramps on exercise
Vancose veins
Poor circulation
None ☐

GASTROINTESTINAL
Ulcers/gastritis
Severe/frequent abdominal pain
Tarry/Black bowel movements
Yellow/Jaundice
Vomit blood, Hepatitis
None ☐

GYNECOLOGICAL/WOMEN
Pregnant now ?
Abnormal / irregular periods
Date last period
Age periods stopped.
None ☐

MUSCULOSKELETAL
General joint pain/arthritis
Joint swelling
Spinal pain
None ☐

ENDOCRINE
Diabetes
Thyroid abnormality
Gout
Osteoporosis
None ☐

NEUROLOGICAL
Fainting
Convulsions
Dizziness
Shakiness/trembling
Diffuse muscle weakness
Tinglng in extremities
None ☐

URINARY
Kidney Stones
Blood in your urine
Frequent/Painful urination
Recurrent Kideny/Bladder infections
None ☐

PSYCHIALTRIC
Psychiatric Hospitalization
Depression
Frequent Mood Swings
History of substance abuse
None ☐

OTHER
AIDS/HIV
Tested positive for HIV? Yes ☐ No ☐ When ?

I attest that the above information is ture and correct to the best of my knowledge and recollection.

Signature of Patient or Legal Representative _____ Date.

HIPAA Notice of Privacy Practices

PHYSICAL THERAPY REFERRAL
MEDSTAR PHYSICAL THERAPY

www.medstarinc.com info@medstarinc.com

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are perrnitted or required by law. It also describes you rights to access and control your protected health information. "Protected health information" is information about you, including demographic information. That may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USED AND OSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health car bills . to support the operation of the physician's practice, and any other use required by law.

Treatment :

We will use and disclose your protected health information to provide, coordinate. Or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ansure that the physician has the necessary information to diagnose or treat you.

Payment :

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations :

We may use or disclose, as-needed , your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review. Training of medical students, licensing, fundraising. And conducting or arranging for other business activities. For example we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you be name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to ramind you of your appointment , and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, publice health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disciosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke the authorization , at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply)- Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding , protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to recelve confidential communications – You have the right to request confidential communication from us by altemative means or at an altematives. You have he right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttel.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations: required by law, that occurred prior to april 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronicalty . We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You mau complain to us or to the Secretary oh Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. We will not retaliate you for filling a complaint.

Office of Civil Rights

U.S. Department of Health and Human Services

50 United Nations Plaza – Room 322

San Francisco, CA 94102

We are required by law to maintain the privacy of, and provides individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

PLEASE SIGN THE ACCOMPANYING " ACKNOWLEDGMENT " FORM. PLEASENOTE THAT BY SIGNING THE ACKNOWLEDGMENT FORM YOU ARE ONLY ACKNOWLEDGING THAT YOU HAVE RECEIVED OR BEEN GIVEN THE OPPORTUNITY TO RECEIVE A COPY OF OUR NOTICE PRIVACY PRACTICES.

HIPAA COMPLIANCE PLAN – PRIVACY RULE

PF – 2000 Acknowledgement of Recaipt of Notice of Privacy Practices

Our practice reserves the right to modify the privacy practices outlined in the notice.

Signature

I have received a copy of the Notice of Privacy Practices for the

Name Of Patient (Print or Type)
Signature of Patient
Date
Signature of Patient Representative **(Required if the patient is a minor or an adult who is unable to sign this form)**
Relationship of Patient Rapresentative to Patient

Cancellation Policy

Cancellation of an Appointment

In order to be respectful of the medical needs of all our patients please be courteous and call our office promptly if you are unable to attend an appointment. This time will reallocated to someone who is in urgent need of treatment. This is how we can best serve the needs of all our patients.

If it is necessary to cancel your scheduled appointment we require that you call 24 hours in advance. Appointment are in high demand, and your early cancellation will give another person the possibility to have access to timely care.

How to Cancel Your Appointment

To cancel appointments you may call (818)244-0009

Late Cancellations

Late cancellations will be considered as a " no show "

No Show Policy

A " no show " is someone who misses an appointment without canceling it 48 hours in advance. No shows inconvenience those individuals who need access to medical care in a timely manner.

A failure to present at the time of a scheduled appointment will be recorded in our appointment scheduler as a " no show ". The first time there is a " no show " or the patient have failed to show up for an appointment and did not cancel the appointment in time, there will be a charge of $50.00.