Patient Registration Form

Patient Name:	Name You Go By:
Address, City, State, Zip:	
DOB:	Social Security #:
Email Address:	
Home Phone:	Appointment Reminder Method
Cell Phone:	☐ Home Phone ☐ Cell Phone
Work Phone:	☐ Work Phone ☐ Email

Please keep in mind that communication via email over the Internet is not a secure form of communication. Providing your contact information with checking the appointment reminder method and signing below, you agree to receive information (such as appointment reminders, patient surveys, and other information relating to the physical therapy services provided to you) via the communication channels for which you provided.

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Partner's Name:
Financial Responsibility: ☐ Self ☐ Other, Please List:	
2nd Contact Name/Address:	
2nd Contact Phone:	Relation:
General Physician:	Referred By:

Have you had Physical Therapy treatment since January of this year? ☐ Yes ☐ No If yes, # of Visits:
Have you had Chiropractic treatment since January of this year? ☐ Yes ☐ No If yes, # of Visits:
Have you had Home Healthcare in the last 30 days? ☐ Yes ☐ No If yes, Home Healthcare Provider:

INSURANCE INFORMATION Please Note: A copy of your insurance card(s) will be kept on file. The patient is responsible to provide their most current insurance information.

Primary Insurance:		Secondary Insurance:	
Group #:	Policy #:	Group #:	Policy #:
Insured Information:		Insured Information:	

Patient name:

Release of Information

I hereby authorized California Orthopedics & Spine to discuss my personal healthcare information regarding my treatment including diagnosis/prognosis and/or billing and payment for services rendered on my behalf to the person(s) listed below.

Name (print)	Relationship	Phone number
Name (print)	Relationship	Phone number

Patient/Guardian Signature: Date:

Name: ____ **Birthdate:** ________________ **Date:** _________________

Best phone number to contact you: _____________________ **Does this number receive text messages:** ☐ Yes ☐ No

Sex: ☐ Male ☐ Female **Height:** _____________ **Weight:** _____________

Emergency Contact: ___________________________ **Emergency Contact #:** ____________________________

Have you been diagnosed with any cardiac-related problems? ☐ Yes ☐ No
If yes, please explain: ____

Are you diabetic? ☐ Yes ☐ No If yes: ☐ Type I ☐ Type II **Do you have a pacemaker?** ☐ Yes ☐ No

Have you had two or more falls in the past year? ☐ Yes ☐ No

Have you had any fall with injury in the past year? ☐ Yes ☐ No

Have you gained OR lost a significant amount of weight in the last year? ☐ Yes ☐ No
If yes, please explain: ____

Do you have any allergies (including but not limited to medications, supplements, food, stings/insects, bites, etc.)?
☐ Yes ☐ No
If yes, please explain: ____

During the past month have you been feeling down, depressed, or hopeless? ☐ Yes ☐ No

During the past month have you been bothered by having little interest or pleasure doing things? ☐ Yes ☐ No

Have you ever had surgery? ☐ Yes ☐ No
If yes, please explain: ____

<u>CURRENT CONDITION (REASON FOR THERAPY TODAY</u>):

Body part: _________________________ **When did your symptoms first appear:** _______________________________
Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unchanging ☐ Unknown

Rate the severity of your pain on a scale from 0 (least pain) to 10 (severe pain): _______________

How often do you have this pain? __________________ **Is it constant or does it come and go?** ____________________

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

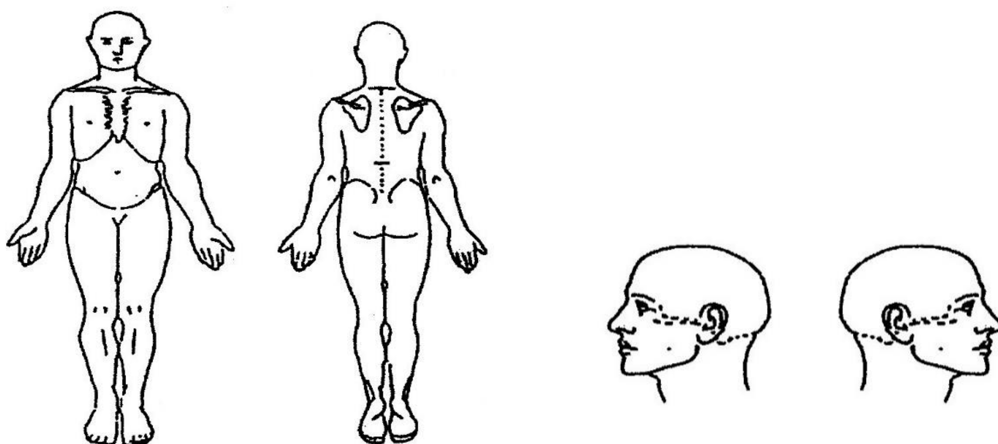
Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending
☐ Lying Down ☐ Reaching ☐ Other ____

My pain is: ☐ Sharp ☐ Burning ☐ Dull ☐ Tingling ☐ Aching ☐Numbness

☐Throbbing ☐ Stiffness ☐ Swelling ☐ Cramps ☐ Shooting ☐ Other

Place a mark on the picture where you have:

xxx = pain +++ = stabbing sss = stiffness ooo = numbness/tingling



I hereby authorize and consent to treatment/services for myself, or on the behalf of the above-named patient performed by the staff at California Orthopedics & Spine Physical Therapy and/or as directed by my referring provider. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including risk or alternatives to the recommended treatment plan.

I assign payment for these services directly to California Orthopedics & Spine Physical Therapy. I authorize the filing of claims to my insurance plan and authorize California Orthopedics & Spine Physical Therapy to release necessary health information related to these services to process the claims. I certify that the information I have provided is accurate and complete.

I acknowledge that I have received the Notice of Privacy Practices, which describes the ways the practice may use or disclose my healthcare information. I understand that my healthcare information may be used for treatment, payment, healthcare operations and other permitted uses or disclosures as described in the Notice.

____ ________________________________

Signature of Patient/Guardian Date

____

Relationship to patient

NO SHOW/ CANCELLATION POLICY

PLEASE READ CAREFULLY

California Orthopedic and Spine Physical Therapy strives to provide each patient with the highest quality care and service. We will make our best effort to schedule these appointments on dates/ times that accommodate your schedule. Your consistent attendance of the planned treatment regimen is paramount to your full recovery. We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable; however, advance notification allows us to fulfill other patient's scheduling needs and keeps the clinic operating at optimal level.

1. Please provide our office with 24-hour notice to change or cancel an appointment. **Patients who do not attend a scheduled appointment or do not provide 24-hour notice to change a scheduled appointment will be responsible for a $75.00 office visit charge.** This charge cannot be billed to insurance and must be paid on or before the next scheduled appointment.
2. If you are more than 15 minutes late, your appointment may need to be rescheduled and a no show will be recorded for that day. If you are aware that you are going to be late, please call the office to let us know.
3. Providing 24-hour notice allows us to place another patient in your cancelled appointment period to receive needed treatment.
4. Your treatment plan has been established by your medical practitioners to get you back to your regular activities as quickly as possible. Missing appointments hinders that process and may end up prolonging recovery.
5. After missing three (3) appointments without notice, you may be placed on a same day scheduling policy for your treatments, which would not allow you to schedule any appointments in advance.

Thank you for providing our office and our patients with this courtesy. Signing below indicates you understand and agree to the terms of this policy.

Signature of Patient/Guardian ___________________________________ Date________________

5 Bon Air Road, Suite 129 Larkspur, California 94939 PHONE: 415-924-8900 FAX: 415-924-7149

Insurance Verification

Patient Name: ____________________________________ Date: ___________________________________

Policy Holder Name: _______________________________ Relationship: ____________________________

Insurance Company (Primary)______________________ Insurance (Secondary)_____________________

In Network: □Yes □ No Out of Network: □Yes □ No

Reference Number: ___________________________ Certification Number: ______________________

Certification Details: ____

Primary Deductible: _______________________________ Amount Met: _____________________________

Secondary Deductible: _____________________________ Amount Met: _____________________________

Primary Out of Pocket Max: ________________________ Amount Met: _____________________________

Secondary Out of Pocket Max: ______________________ Amount Met: _________________________

Copay per visit: □Yes □ No Amount: ______________________________

Co-Insurance per visit: □Yes □ No Amount: ______________________________

Number of visits per year: ________________ Number Remaining: ____________________

Therapy Max: __________________________

The information above has been recorded based on the benefits and eligibility supplied to us by your insurance carrier and is not a guarantee of payment or benefits. **Estimated coverage information is provided as a courtesy to our patients but is not intended to release them from total responsibility for their account balance. It is our policy to bill your insurance carrier as a courtesy to you, although you are responsible for the entire bill when services are rendered**. We require that an arrangement for payment of your estimated share be made today. If payment is made directly to you for services billed by us, you recognize an obligation to promptly remit the same to California Orthopedics & Spine.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by California Orthopedics & Spine, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

If further therapy is required beyond the above authorization period, I will follow-up to make sure that any additional authorization has been obtained from the insurance carrier prior to any additional treatment, if this is required by my insurance company. If I incur rehabilitation without appropriate authorization from my carrier, I will be responsible for the charges in full as well as any non-covered services. **I will also be liable for all treatment that exceeds what is allowed by my insurance plan. It is my responsibility to ensure this information remains valid throughout my treatment.**

Signature of Patient or Responsible Party: ______________________________ Date: _____________________