

# PATIENT REGISTRATION & BILLING INFORMATION FOR MINORS

Albany Physical Therapy 948 San Pablo Ave. Albany, CA 94706 (510) 526-2353

**PATIENT NAME** \_\_\_\_\_ **DATE** \_\_\_\_\_

( ) Single ( ) Married

**ADDRESS** \_\_\_\_\_ **HOME PHONE** \_\_\_\_\_

**CITY** \_\_\_\_\_ **STATE** \_\_\_\_\_ **ZIP** \_\_\_\_\_ **CELL PHONE** \_\_\_\_\_

**BIRTHDATE** \_\_\_\_\_ **AGE** \_\_\_\_\_ **SEX** \_\_\_\_\_ **E-MAIL** \_\_\_\_\_

(For appointment reminders)

**PARENT / GUARDIAN NAME** \_\_\_\_\_ **DOB** \_\_\_\_\_

**EMPLOYED BY** \_\_\_\_\_ **WK PH** \_\_\_\_\_

**OCCUPATION** \_\_\_\_\_ **CELL PHONE** \_\_\_\_\_

Person to call in case of emergency \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

DOCTOR WHO REFERRED YOU \_\_\_\_\_ DATE **CURRENT** SYMPTOMS BEGAN \_\_\_\_\_

Is your condition related to an accident (auto, work, or other): \_\_\_\_\_ If yes, date of injury \_\_\_\_\_

## METHOD OF PAYMENT

1) **PRIMARY INSURANCE** \_\_\_\_\_ ID# \_\_\_\_\_

Primary Subscriber's Name \_\_\_\_\_ DOB: \_\_\_\_\_ Group # \_\_\_\_\_

Employer \_\_\_\_\_ Your relation to subscriber: SELF SPOUSE CHILD OTHER

**SECONDARY INSURANCE** \_\_\_\_\_ ID# \_\_\_\_\_

Primary Subscriber's Name \_\_\_\_\_ DOB: \_\_\_\_\_ Group # \_\_\_\_\_

Employer \_\_\_\_\_ Your relation to subscriber: SELF SPOUSE CHILD OTHER

2) **AUTO ACCIDENT** (or other accident insurance info)

INSURANCE CO. NAME \_\_\_\_\_ PHONE # \_\_\_\_\_

ADDRESS \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

ADJUSTER'S NAME \_\_\_\_\_ PHONE # \_\_\_\_\_

DATE OF INJURY \_\_\_\_\_ CLAIM # \_\_\_\_\_

Is this your insurance plan: \_\_\_\_\_ If not, is it the ins. of the car you were in? \_\_\_\_\_ or other car's ins \_\_\_\_\_

Do you have Med Pay on your policy? \_\_\_\_\_ If yes, how much \$ \_\_\_\_\_ Have you used any? \$ \_\_\_\_\_

Attorney's Name (if represented) \_\_\_\_\_ Phone # \_\_\_\_\_

## Consent to treatment of minor child:

I hereby authorize any Physical Therapist at Albany PT to administer treatment as deemed medically necessary to my  son  daughter \_\_\_\_\_.

(Grandchild, etc)

Child's Name \_\_\_\_\_

Parent / Guardian's Signature \_\_\_\_\_

Witnessed by: \_\_\_\_\_

Staff member at Albany PT

**SEE OTHER SIDE →**

## **Assignment of insurance benefits & authorization to release medical information:**

I hereby instruct my insurance company, or attorney, to pay to Albany Physical Therapy any benefits allowable for their professional services rendered to my child by their office. I shall be personally liable for any unpaid balance. Furthermore, I authorize Albany Physical Therapy to provide to my insurance company (or other entities I have signed a release with) any and all information they may require concerning my child's case.

### **Cancellation Policy:**

- ❖ If you need to cancel an appointment we require at least a 24 hour notice
- ❖ If you do not give at least a 24 hour notice to cancel, or if you do not show up for your appointment ("no show"), you will be required to pay a **\$75 fee** for the time we had reserved in your name. Your insurance will not pay this fee.
- ❖ After 2 late cancellations or 2 no shows, we will cancel all future appointments. If you want to continue therapy with our office, you will be required to call in each day to see if your physical therapist has an appointment available, or you may choose to find another facility that is more conveniently located. We will not schedule future appointments in advance.

### **Late Arrival Policy:**

In consideration of other patients, your appointment time cannot be extended if you do not arrive on time. The therapist will determine if there is sufficient time to render quality care in the time remaining for your scheduled appointment.

### **Patient Privacy Information Acknowledgement Form**

I have read and fully understand Albany Physical Therapy's Notice of Patient Privacy Practices, which is displayed in the patient waiting area, and which I may request a copy of at any time. I understand Albany Physical Therapy may use or disclose my personal health information for the purposes listed, such as carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment and 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 in writing. I also understand that Albany Physical Therapy 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 Albany Physical Therapy's Notice of Patient Privacy Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

My signature below is confirmation that I agree to and understand all of the above information.

**Parent/Guardian's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Please show your insurance card & photo ID to the receptionist.  
Please remember to notify our office immediately upon any changes to your  
address, phone number, or insurance coverage.

**NAME** \_\_\_\_\_ **HEIGHT** \_\_\_\_\_ **WEIGHT** \_\_\_\_\_

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question, leave it blank and your therapist will assist you. Thank you!

**Have you EVER been diagnosed as having any of the following conditions?**

| YES | NO |                                       | Date first Diagnosed | YES | NO |                                 | Date first diagnosed |
|-----|----|---------------------------------------|----------------------|-----|----|---------------------------------|----------------------|
|     |    | Pacemaker                             |                      |     |    | Rheumatoid Arthritis            |                      |
|     |    | Diabetes                              |                      |     |    | Osteoarthritis                  |                      |
|     |    | Heart Problems                        |                      |     |    | Osteoporosis/Osteopenia         |                      |
|     |    | High Blood Pressure                   |                      |     |    | Depression                      |                      |
|     |    | Circulation Problems                  |                      |     |    | Stroke                          |                      |
|     |    | Asthma                                |                      |     |    | Kidney Disease                  |                      |
|     |    | Emphysema/Bronchitis                  |                      |     |    | Anemia                          |                      |
|     |    | Chemical Dependency (i.e. Alcoholism) |                      |     |    | Epilepsy                        |                      |
|     |    | Thyroid Problems                      |                      |     |    | Hepatitis or Tuberculosis       |                      |
|     |    | Cancer. If YES, describe what kind:   |                      |     |    | Multiple Sclerosis / Autoimmune |                      |
|     |    |                                       |                      |     |    | Other:                          |                      |

- YES NO 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 in doing things?  
 YES NO Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way?  
 YES NO FOR WOMEN ONLY: Are you currently pregnant or think you might be pregnant?

**Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:**

- |             |   |             |   |
|-------------|---|-------------|---|
| Date: _____ | Reason for Surgery/Hospitalization: _____ | Date: _____ | Reason for Surgery/Hospitalization: _____ |
| 1. _____    | _____                                     | 3. _____    | _____                                     |
| 2. _____    | _____                                     | 4. _____    | _____                                     |

**Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:**

- |             |               |             |               |
|-------------|---------------|-------------|---------------|
| Date: _____ | Injury: _____ | Date: _____ | Injury: _____ |
| _____       | _____         | _____       | _____         |
| _____       | _____         | _____       | _____         |

**Which of the following OVER-THE-COUNTER medications have you taken in the last week?**

- |                               |                                     |
|-------------------------------|-------------------------------------|
| YES NO Aspirin                | YES NO Antihistamines               |
| YES NO Tylenol/Acetaminophen  | YES NO Antacid                      |
| YES NO Advil/Motrin/Ibuprofen | YES NO Vitamins/Mineral Supplements |
| YES NO Laxatives              | YES NO Other: _____                 |
| YES NO Decongestants          |                                     |

**Please list any medication you are currently taking, including over the counter, herbals, and vitamin supplements. Please indicate the route (example: oral, injection, skin patch, etc.) Also include dosage and frequency. Use additional page if more room is needed.**

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_  
 4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

**Steroid Use? E.g. Inhalers, Injections, Oral Steroids**

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

**Have you had any diagnostic tests? (X-Ray, MRI, Bone Density) Include dates.**

- YES NO \_\_\_\_\_ Where? \_\_\_\_\_ Date: \_\_\_\_\_

**Have you recently noted:**

- |                         |                            |                             |
|-------------------------|----------------------------|-----------------------------|
| YES NO Weight Loss/Gain | YES NO Weakness            | YES NO Fatigue              |
| YES NO Nausea/Vomiting  | YES NO Fever/Chills/Sweats | YES NO Numbness or Tingling |



**Patient Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

\*\*PLEASE CHECK OTHER SIDE\*\*

Reviewed \_\_\_\_\_ Reviewed \_\_\_\_\_ Reviewed \_\_\_\_\_  
 Date & Initials Date & Initials Date & Initials

## Informed Consent to Treatment of Minor Child

**Informed Consent:** I understand the expected benefit of physical therapy and I understand that I can refuse any procedure prior to its performance. I hereby consent to the procedures which may be performed while I am a patient of Albany Physical Therapy (“APT”) under the direction of a Licensed Physical Therapist. This may include but is not limited to: examination, evaluation, physical testing, application of modalities such as hot/cold pack, electrical stimulation, ultrasound, etc, application of therapeutic procedures intended to improve function including therapeutic exercises, neuromuscular rehabilitation, gait training, manual or mechanical traction, soft tissue mobilization, joint mobilization, and any other procedure under the scope of physical therapy practice. I give consent to and release Albany Physical Therapy, PC from liability arising from providing CPR, AED and any other emergency medical assistance in the event of an emergency.

Parent/Guardian

Signature \_\_\_\_\_ Print Name \_\_\_\_\_

Patient

Signature \_\_\_\_\_ Print Name \_\_\_\_\_

**Waiver of Claims and Release of Liability:** I understand that fitness activities, especially strength and aerobic training, can lead to serious physical injuries. If, as part of my treatment, my therapist assigns independent gym exercises, I acknowledge and agree that I am solely responsible for my safe and responsible use of the equipment at Albany Physical Therapy (APT) whether or not supervised by an APT representative. In consideration for the use of the facilities, I hereby expressly assume the risk that I may suffer injury as a result of my use of APT’s facilities or equipment. I agree for myself and on behalf of my guests, heirs, representative, successors and assigns (“User Parties”) that APT, including its owner, members, directors, employees and agents (“APT parties”) will not be liable for any damages or injuries I or User Parties may suffer in or about APT. I agree for myself and on behalf of User Parties that none of us will make any claim against, sue, or attach the property of APT Party or affiliate thereof, whether such claims arise from the negligence of the APT Party or otherwise, to the full extent permitted by law, and that each of us will hold harmless all such APT Parties for any such claims. I also agree that APT will not be liable for any loss, theft, or damage to my personal property in or about APT, including any personal property stored on the premises. If any portion of the Waiver of Claims and Release of Liability is held invalid, the remainder shall continue in full legal force and effect.

Parent/Guardian

Signature \_\_\_\_\_ Print Name \_\_\_\_\_

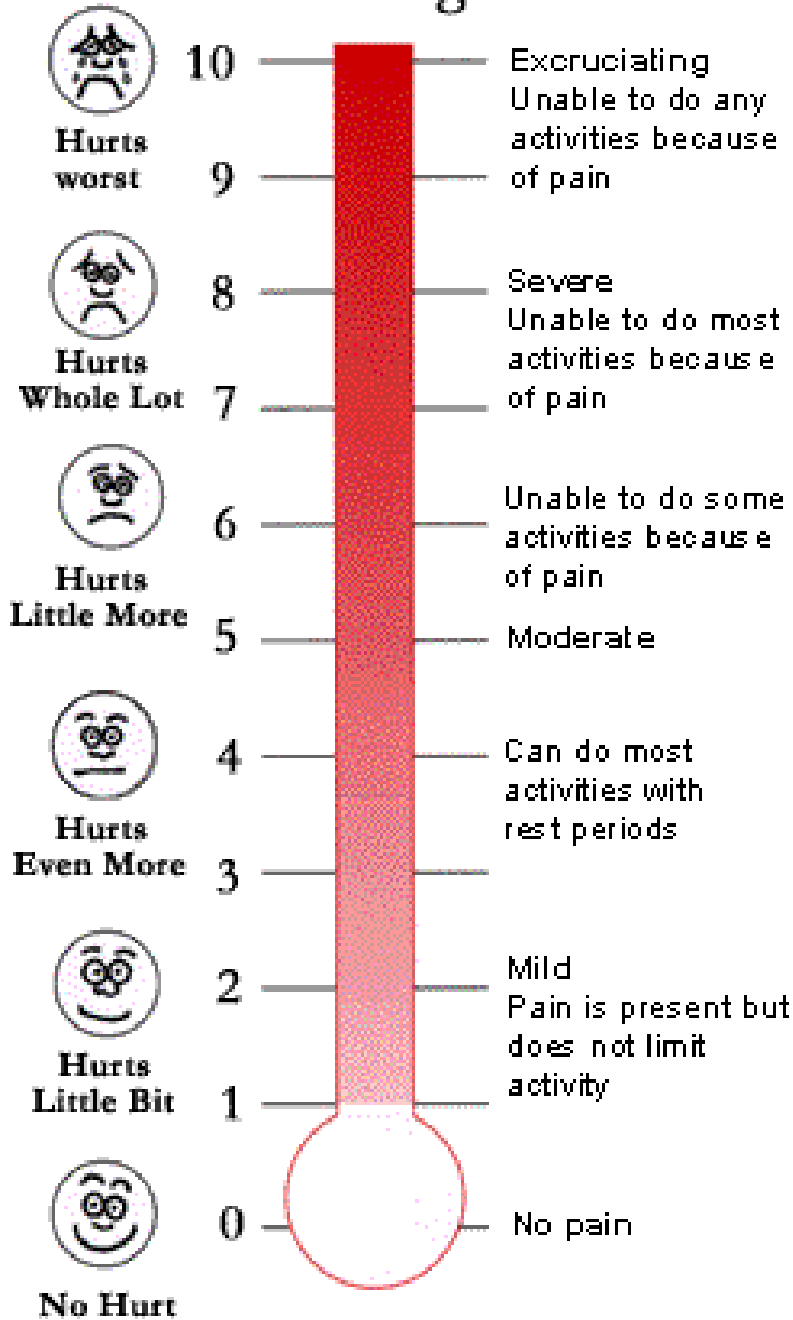
Date \_\_\_\_\_

\*\*PLEASE CHECK OTHER SIDE\*\*

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please answer the questions (A, B, & C) in the box to the right, as they relate to your pain level for the problem you are having assessed in physical therapy today. 10 represents the worst pain and 0 indicates no pain at all.

## Pain Rating Scale



**Based on the descriptions to the left, please answer the following questions using the pain scale 0-10**

A) What is your pain level today?

\_\_\_\_\_

B) Over the past week, what was your pain level at its worst?

\_\_\_\_\_

C) Over the past week, have you ever been pain-free? If so, enter 0. If not, enter the number which corresponds with the least amount of pain you've experienced in the past week.

\_\_\_\_\_

Additional Notes:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_