PATIENT REGISTRATION & BILLING INFORMATION

Albany Physical Therapy

A Professional Corporation

948 San Pablo Ave ~ Albany, CA 94706 ~ (510) 526-2353

NAME_____DATE_____

( ) Single ( ) Married ( ) Partner ( ) Widowed ( ) Divorced ( ) Other

ADDRESS_____ CITY_____STATE_____ ZIP_____

PHONE: HOME_____ WORK_____ CELL_____

E-MAIL: _____

BIRTHDATE_____AGE_____SEX_____HEIGHT_____WEIGHT_____

EMPLOYED BY_____OCCUPATION_____

SPOUSE'S NAME_____DOB_____WK PH_____

SPOUSE'S EMPLOYER_____OCCUPATION_____

EMERGENCY CONTACT_____ 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) **WORKER'S COMP. INS**_____CLAIM#_____

Address_____City_____State_____Zip_____

Adjuster's Name_____Phone #_____Date of Injury_____

Employer Name (at time of injury) _____Are you currently working_____

Date of injury _____If not currently working, date you are to return_____

3) **AUTO ACCIDENT** (or other accident ins. info) Date of Injury_____Claim# _____

INSURANCE CO. NAME_____PHONE #_____

ADDRESS_____City_____State_____Zip_____

ADJUSTER'S NAME_____PHONE #_____

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 #_____

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 me 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 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. If you are more than 10 minutes late, the therapist may determine that there is insufficient time to provide proper treatment, and you may be charged our $75 missed appointment fee.

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.

Patient's Signature _____Date_____

Please show your insurance card and a photo ID to the receptionist. Please remember to notify our office immediately upon any changes to your address, phone #, 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?

			Date first Diagnosed				Date first diagnosed
YES	NO	Pacemaker		YES	NO	Rheumatoid Arthritis	
YES	NO	Diabetes		YES	NO	Osteoarthritis	
YES	NO	Heart Problems		YES	NO	Osteoporosis/Osteopenia	
YES	NO	High Blood Pressure		YES	NO	Depression	
YES	NO	Circulation Problems		YES	NO	Stroke	
YES	NO	Asthma		YES	NO	Kidney Disease	
YES	NO	Emphysema/Bronchitis		YES	NO	Anemia	
YES	NO	Chemical Dependency (i.e. Alcoholism)		YES	NO	Epilepsy	
YES	NO	Thyroid Problems		YES	NO	Hepatitis or Tuberculosis	
YES	NO	Cancer. If YES, describe what kind:		YES	NO	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 Tylenol/Acetaminophen
YES NO Advil/Motrin/Ibuprofen
YES NO Laxatives
YES NO Decongestants
YES NO Antihistamines
YES NO Antacid
YES NO Vitamins/Mineral Supplements
YES NO Other: _____

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**

Reviewed _____ Reviewed _____ Reviewed_____

PLEASE CHECK OTHER SIDE Date & Initials Date & Initials Date & Initials

Informed Consent to Treatment

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.

Print Name _____ Signature _____

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.

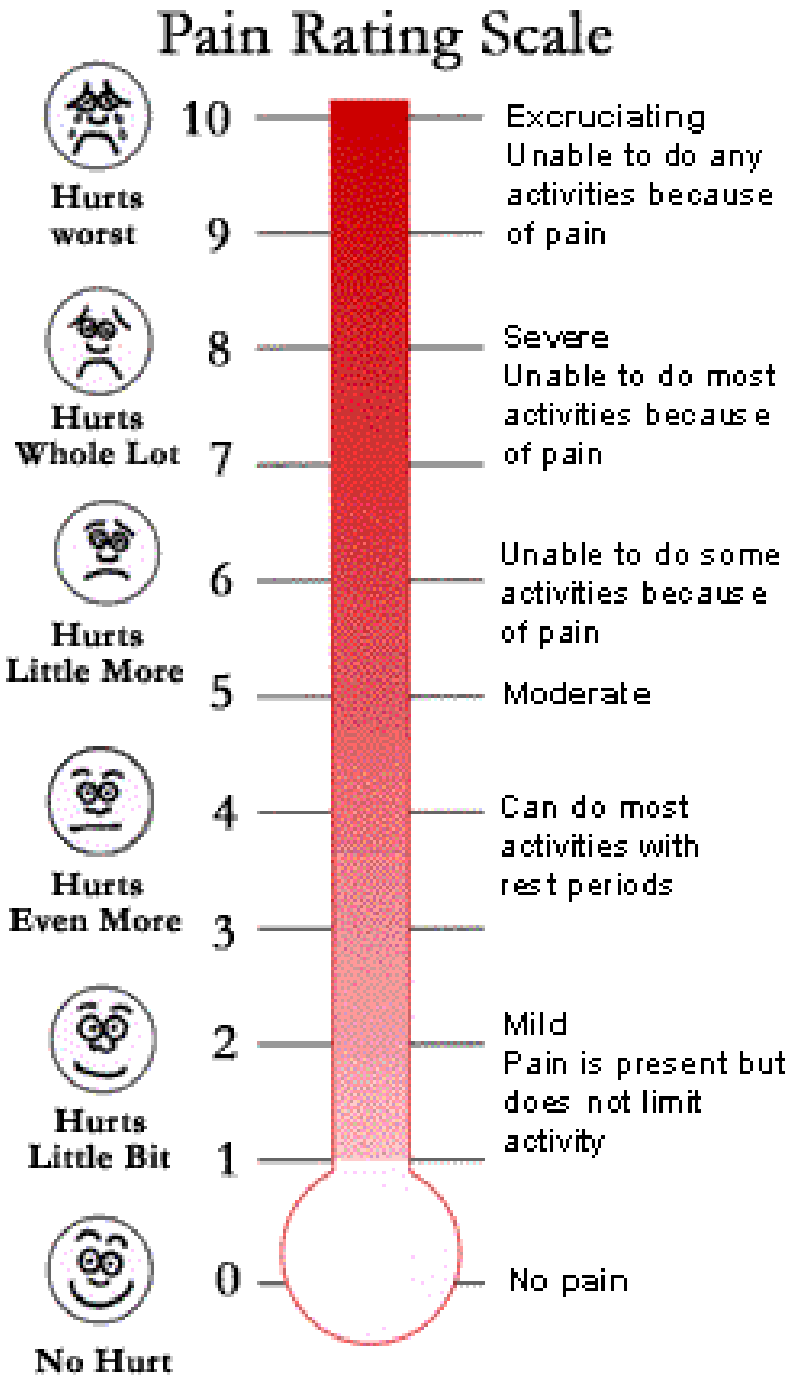
Print Name _____ Signature _____

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.



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:

_____

_____

_____

_____

PLEASE CHECK OTHER SIDE

Updated 5/24/17