PHYSICAL THERAPY ASSOCIATES, LLC. -- PATIENT REGISTRATION FORM

Please fill out this form to register as a patient of Physical Therapy Associates, LLC. All fields with an asterisk (*) are REQUIRED. We cannot register you as a Physical Therapy Associates, LLC. patient without this information.

PATIENT INFORMATION			
*Name: LAST , FIRST M.I.		Account Number:	Diagnosis:
*Gender: Male ☐ Female ☐	*Date of Birth:	Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐	
*Address:		*City:	*State: *Zip Code:
*Home Phone:	*Mobile Phone:	*Email Address:	
*Employer/School:		Employ Status: FT ☐ PT ☐ Not Employed ☐ Retired ☐ Active Duty ☐ Self ☐	
Address:		City:	State: Zip Code:
Work Phone:	Occupation:	Student Status: FT ☐ PT ☐	
*Is this injury related to a Work or Auto accident? Yes ☐ No ☐		*Date of Injury: / /	

GUARANTOR INFORMATION (person that is responsible for the bill)			
*Name: LAST , FIRST M.I.		*Date of Birth: / /	
*Address:		*City:	*State: *Zip Code:
*Home Phone:	*Relationship to Patient:	Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐	

INSURANCE COVERAGE & SUBSCRIBER INFORMATION (person that has the insurance policy)			
*Primary Insurance Name:		*Subscriber's Name: LAST , FIRST M.I.	
*Gender: Male ☐ Female ☐	*Date of Birth:		* Relationship to Subscriber:
*Policy No.:		*Group No.:	*Plan No.:
Secondary Insurance Name:		*Subscriber's Name: LAST , FIRST M.I.	
*Gender: Male ☐ Female ☐	*Date of Birth:		* Relationship to Subscriber:
*Policy No.:		*Group No.:	*Plan No.:
Tertiary Insurance Name:		*Subscriber's Name: LAST , FIRST M.I.	
*Gender: Male ☐ Female ☐	*Date of Birth:		* Relationship to Subscriber:
*Policy No.:		*Group No.:	*Plan No.:

*Emergency Contact:	*Relationship to Patient:	*Phone No.:
If patient is a child, who may authorize treatment for this child?	Relationship to Patient:	Phone No.:

*Would you prefer appointment reminders be texted to a mobile phone or emailed?

Texted to a mobile phone ☐ Emailed ☐

*Who is your Primary Care Physician (PCP)?

*Do you authorize release of your medical information to anyone besides the referring physician, emergency contact, and your insurance carrier(s)?

Yes ☐ No ☐

If so, whom?

PHYSICAL THERAPY ASSOCIATES, LLC.

Attention: All Patients

As a service to our patients, our staff will assist you with the filing of your insurance claims. Each and every insurance plan varies in the amounts and type of medical coverage offered. It is between you and your insurance company to understand your benefits. We will gladly check on your benefits upon your request, however it is to your advantage to understand your plan and be aware of any limitations.

1. If your Primary insurance Company does not cover our services in full, you are responsible for the remaining amounts(s) due.
2. Your insurance plan may have a deductible and/or co-pay that you will be responsible for. As a courtesy to you, we will contact your insurance company to find out your deductible and/or co-pay.
3. We will file with your secondary insurance as long as you provide us with all pertinent information. If you would like our assistance, please notify us immediately so that we can obtain any pre-authorizations that may be necessary (i.e.: Champus, Queen's Health Care Plan, UHA, KHH, etc.)

Attention: Medicare Patients

Effective January 1, 2000 – Medicare will pay 80% of eligible fees after your deductible has been met. Medicare has a $100.00 annual deductible (this may have been met with another doctor seen prior to us). You are responsible for your $100.00 deductible and 20% of the eligible fee. In the case that you have a secondary insurance, Medicare will forward the remaining 20% to your secondary insurance carrier.

Your responsibility is a percentage per visit:

I have read and understand the above statements regarding my insurance plans (if applicable). I authorize PHYSICAL THERAPY ASSOCIATES, LLC to release to my insurance company or its representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical care. I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Champus, private insurance, and any other health plan to PHYSICAL THERAPY ASSOCIATES, LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I understand that I will be assessed the bank charge for each check returned due to insufficient funds. In the event of default, I (We) promise to pay legal interest on the indebtness, together with such collection costs and reasonable attorney fees as may be required to affect collection of this note. I hereby authorize PHYSICAL THERAPY ASSOCIATES, LLC. to release all information necessary to secure payment and treatment.

_____ _____

Patient, Parent or Guardian's Signature: Date

Patient Name**:**

770 Kapiolani Blvd., Suite 104 * Honolulu, HI 96813
Phone: (808) 596-9446 * Fax: (808) 596-9160

PHYSICAL THERAPY ASSOCIATES, LLC.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Physical Therapy Associates, LLC. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Physical Therapy Associates' Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Physical Therapy Associates, LLC. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Physical Therapy Associates, LLC. Privacy Officer at 770 Kapiolani Blvd., Suite 104, Honolulu, HI 96813. With my consent, Physical Therapy Associates, LLC. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including x-ray or MRI results among others.

With my consent, Physical Therapy Associates, LLC. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential".

I have the right to request that Physical Therapy Associates, LLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Physical Therapy Associates, LLC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Physical Therapy Associates, LLC may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Relationship to Patient

Patient's Name:

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PHYSICAL THERAPY ASSOCIATES, LLC.

Medical History Form

Name:	
Is an Attorney involved in this case? ☐ Yes ☐ No	Date / Type of surgery:
Have you had Surgery for this injury? ☐ Yes ☐ No	_____
Are you or do you think you might be pregnant? ☐ Yes ☐ No	Do you smoke? ☐ Yes ☐ No

Please list all Prescription and Non Prescription Medication that you are currently taking below to the best of your knowledge:

_____

List all daily activities that are difficult to perform due to your pain:

List any activities you are currently not able to perform but would like to resume:

Have you had any of the following Services for this injury/illness? (Please mark all that apply)

☐ Physical Therapy ☐ Orthopedist ☐ Chiropractic
☐ Emergency Room Care ☐ X-rays, MRI, CT Scan ☐ Massage Therapy
☐ Podiatrist ☐ Neurologist ☐ Other: _____

Do you now have or have you EVER had ANY of the following? (Please mark all that apply)

☐ Heart problems or surgery ☐ Asthma or other breathing problems ☐ Gout
☐ Osteoporosis ☐ Emotional/Psychological problems ☐ Infectious disease
☐ Diabetes ☐ Dizziness or Fainting ☐ Sleeping problems
☐ Cancer/Tumor ☐ Thyroid/Goiter problem ☐ Weight or energy loss
☐ High Blood Pressure ☐ Migraines ☐ Any type of implants
☐ Stroke / TIA ☐ Vision or hearing problems ☐ Neck surgery
☐ Seizures / Epilepsy ☐ Anemia ☐ Back surgery
☐ Hernia ☐ Arthritis ☐ Shoulder surgery
☐ Numbness or tingling ☐ Weakness ☐ Hip/knee surgery
☐ Allergies ☐ Varicose veins ☐ Elbow/wrist/hand surgery
☐ Joint replacement ☐ Shortness of breath or chest pain ☐ Leg/Ankle/Foot surgery
☐ Bowel or bladder problems ☐ Pacemaker/Nitroglycerin patch

Patient/Guardian Signature: _____ Date: _____

This form has been reviewed by: _____ Date: _____

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