**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
# Informed Consent and Release of Liability

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis, and intervention by use of rehabilitative procedures., mobilization, massage, exercises, and physical agents to aid patients in achieving their maximum potential within their capabilities. These services are provided in response to a wide range of medical care needs of outpatients of all ages, regardless of gender, color, ethnicity, creed, or disability. All procedures will be thoroughly explained to you before you are asked to perform them.

Response to physical therapy intervention varies from person to person, and therefore, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. Physical Therapy Associates, LLC ("**PT Associates**") does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition for which you are seeking treatment.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. There are certain inherent risks with physical therapy treatments because you will be asked to exert effort and perform activities with increasing levels of difficulty that could increase your level of pain or discomfort with a current or previous injury. You will be able to stop treatment if you feel any discomfort or pain. Your therapist will take every precaution to ensure that you are protected from any potentially hazardous situation. You will never be forced to perform any procedure that you do not wish to perform.

Due to the nature of services provided, you may be asked to disrobe. If this is necessary, your privacy, modesty, and dignity will be considered at all times by the staff. Should you feel uncomfortable or embarrassed, you may refuse the procedure, stop the procedure and/or request another therapist.

I hereby release PT Associates, Bryan Lee, Paul Matsumoto and their employees from any responsibility or liability due to my participation in physical therapy. I am fully aware that I am participating in these sessions at my own risk and will not hold those named above responsible in the event of my incurring an injury or exacerbating any previously existing conditions. If I have any medical conditions, I have consulted with my physician to make sure that physical therapy is appropriate for me to participate in. I authorize release of my medical information to appropriate third parties.

Print Name: _____ Signature: _____

Date: _____

If Under 18 Years of Age:

Parent or Legal Guardian Name and Signature: _____

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

**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.

If your Primary insurance Company does not cover our services in full, you are responsible for the remaining amounts(s) due, including annual deductibles and co-pay. 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.: Queen's Health Care Plan, UHA, HMA, PSWA 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 co-payment per visit:**

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## 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

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## PHYSICAL THERAPY ASSOCIATES, LLC.

### Medical History Form

Is an Attorney involved in this case? ☐ Yes ☐ No
Have you had Surgery for this injury? ☐ Yes ☐ No
Date / Type of surgery:

Are you or do you think you might be pregnant?
☐ Yes ☐ No
Do you smoke? ☐ Yes ☐ No

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

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

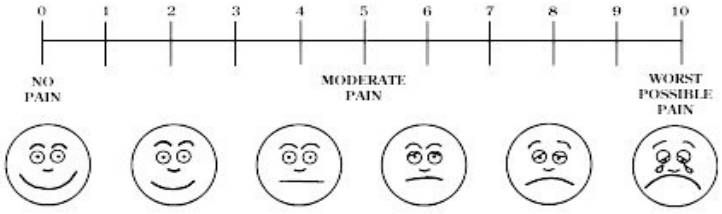
**Have you had any of the following Services for this injury/illness?** (Please mark all that apply)

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

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

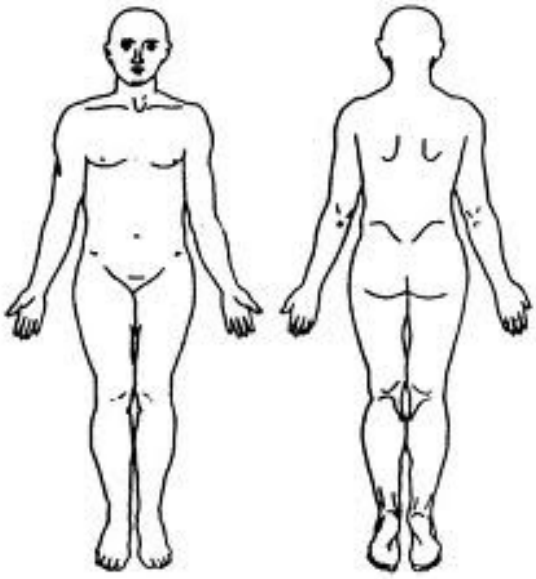
| | | | |
|---|---|---|---|
| ☐ Heart problems/surgery | ☐ Dizziness/Fainting | ☐ Gout | ☐ Any type of implants |
| ☐ Osteoporosis | ☐ Thyroid/Goiter problem | ☐ Sleeping problems | ☐ Neck surgery |
| ☐ Diabetes | ☐ High Blood Pressure | ☐ Weight/energy loss | ☐ Hernia |
| ☐ Cancer/Tumor | ☐ Stroke/TIA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

*** Place an "X" at the level of pain you are currently experiencing on the diagram below.**



Pain Management Scale

*** Mark the location of your pain(s) on the above diagram.**



Patient/Guardian Signature: _____ Date: _____

This form has been reviewed by: _____ Date:_____

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