New Patient Registration

<table>
<tr><td colspan="2">Patient Name</td><td colspan="2">DOB</td><td>SEX
☐ Male
☐ Female</td><td colspan="2">Marital Status
☐ Single ☐ Married
☐ Widowed ☐ Divorced</td></tr>
<tr><td colspan="2">Residence Address</td><td colspan="2">City</td><td>State</td><td colspan="2">Zip Code</td></tr>
<tr><td>Home Phone #</td><td>Cell Phone #</td><td colspan="2">Work Phone #</td><td colspan="3">Email</td></tr>
<tr><td colspan="2">If minor, parent or guardian's name</td><td colspan="2">Social Security #</td><td colspan="2">Driver's License #</td><td>Occupation</td></tr>
<tr><td colspan="2">Name of Employer</td><td colspan="4">Address</td><td>Phone #</td></tr>
<tr><td colspan="2">Insurance Company Name</td><td colspan="4">Address</td><td>Phone #</td></tr>
<tr><td colspan="2"></td><td colspan="4"></td><td>Fax #</td></tr>
<tr><td colspan="2">Subscriber's Name</td><td colspan="2">Policy #</td><td colspan="2">Certificate #</td><td>Group #</td></tr>
<tr><td colspan="2">Secondary insurance Company Name</td><td colspan="4">Address</td><td>Phone #</td></tr>
<tr><td colspan="2">Subscriber's Name</td><td colspan="2">Policy #</td><td colspan="2">Certificate #</td><td>Group #</td></tr>
<tr><td colspan="2">Physician's Name</td><td colspan="4">Address</td><td>Phone #
Fax #</td></tr>
<tr><td colspan="2">Emergency contact</td><td colspan="5">Relationship Phone #</td></tr>
</table>

.

Patient Signature: ________________________________ Date: ___________

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7854 Tampa Ave. Reseda Ranch, CA 91335

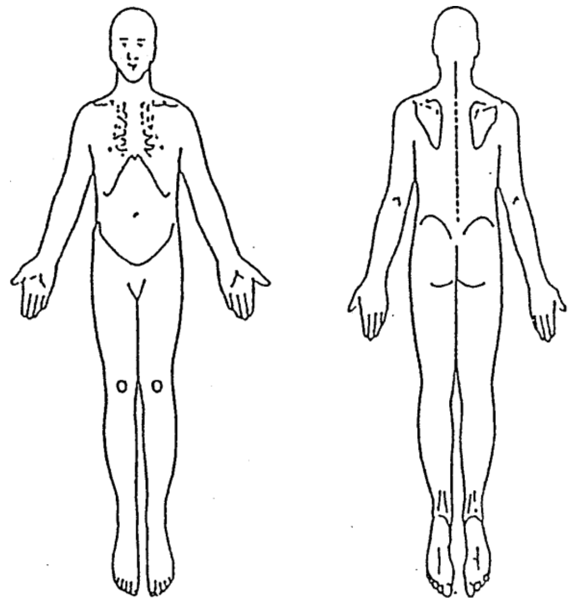
From The Heart™
PHYSICAL THERAPY

Patient History Form

Patient Name: ________________________________ **Date:** _____________

To best serve you, please answer the following questions as completely as possible.

1. Are you currently working? Yes No (If not, please indicate last day worked ____________)
2. What is your occupation and describe the physical demands: ______________________________
____
3. Describe your main complaints and symptoms: ____
____
4. Shade the human model to indicate painful areas.



5. Please rate your pain: 1 2 3 4 5 6 7 8 9 10
6. Which of the following words best describes your pain?
   (**Check all the apply**)
   Sharp Dull Aching Tingling
   Numb Constant Variable Radiating (moves)
7. How did the symptoms start?
____
____
8. What positions or activities make your pain worse?
____
____
9. What positions or activities make your pain better?
____
10. Have you received any treatment or taken any tests for this issue?
____

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Past Medical History

Patient Name: ___________________________________ **Date:** ______________

1. Have you ever had or been diagnosed with any of the following? If yes, please explain:

High Blood Pressure Yes No ____
Heart Trouble Yes No ____
Circulation Issues Yes No ____
Seizures Yes No ____
Dizzy Spells Yes No ____
Diabetes Yes No ____

Other Medical Issues Yes No ____

2. Have you ever had surgery? Yes No If yes, please provide details below:

Procedure:	Date:	Notes:
(1) ___________________________	_____________	_____________________
(3) ___________________________	_____________	_____________________
(2) ___________________________	_____________	_____________________
(4) ___________________________	_____________	_____________________

3. Do you have metal implants? (Other than dental work) Yes No If yes, explain:

____

4. Do you have a cardiac (heart) pacemaker? Yes No

5. Please list any known allergies: ____

6. WOMEN: Are you pregnant? Yes No Date of last menstrual cycle: ___________

7. Have you ever had Physical Therapy Treatments? Yes No If yes, please specify:

____

To the best of my knowledge, I certify that the above information is true and correct.

Patient Signature: ___________________________________

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CONSENT TO TREAT

I, ____________________________________, herby consent to routine physical therapy services as provided by From the Heart Physical Therapy under the supervision of a licensed Physical Therapist. I acknowledge that treatment may include any number of manual procedures, Myofascial Release techniques, exercises and/or modalities that will be rendered as part of the physical therapy treatment program provided by this office.

ACCEPTANCE OF OFFICE POLICIES & FINANCIAL AGREEMENTS

- A valid credit card is required to secure appointment reservations and will be held on-file for future visits. Visa and MasterCard are accepted. **Patient Initials:** __________

- Patients must provide a 48-hour advance notification to cancel or reschedule appointments. If less than 48-hours' notice is given; the patient will be held accountable for the full amount of the service charged to the credit card on file. **Patient Initials:** __________

- Your appointment time is set-aside solely for you; therefore, we appreciate you being on-time. Late arrivals will result in abbreviated treatment time.

- It is your responsibility to notify the office of any change in address, phone, employment, or insurance coverage.

- For **private patients**, payment is required at the time services are rendered. We accept cash, debit, and credit cards.

- For **insurance patients**, I accept full financial responsibility if for any reason my insurance company does not reimburse From the Heart Physical Therapy for my treatments. I will communicate any changes made to my Medicare policy or coverage immediately. Our office will submit your claims to Medicare only up to the first cap of $1980. As a courtesy to our patients we file your insurance at no charge if you provide all insurance information. If we receive a payment from your insurance company, we will issue a refund check to your address on-file.

- Patient Statements***:*** All balances are due in full within 14 days of the statement date. We reserve the right to charge all accounts with a balance over 30 days from billing date a service charge of 1.5% per month. We reserve the right to submit your account in a collection program, report delinquent accounts to credit bureaus, assess a collection fee of up to 40% of the outstanding balance, take other collection action, and/or terminate you as a patient of this practice. In addition, if legal action is taken you will be responsible for the cost, which may be up to $250.00 per hour.

I have read the Office Policies and Financial Agreements and agree to abide by all terms in this document:

Patient Signature: ____________________________________ **Date:** ____________

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Release of Medical Information

Patient Name: ______________________________________ **Date:** ____________

Medical Facility: ____

You are hereby authorized and requested to furnish any and all medical information, history, records, diagnosis, reports and/or radiographs in your possession regarding the above named patient to From The Heart Physical Therapy.

Patient Signature: __________________________________

If patient is a minor, please provided signature of parent of guardian and fill out below:

Printed name of parent or guardian: __________________________________

Relationship: ______________________________________ **Date:** ____________

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Home Health Notification Policy

For All Medicare Beneficiaries

Patient Name: ____ Date: ____________

Our company policy requires that you notify us of any changes concerning Home Health Services received while under our care. According to Medicare regulations, out- patient therapy services will not be covered for if you are enrolled in any Home Health agency. If you are or become enrolled in any home health services without notifying us, you will be personally responsible for all incurred therapy expenses from From The Heart Physical Therapy, Inc.

Patient Signature: ____________________________________

Witness Name: _______________________________________ Date: ____________

Witness Signature: ____________________________________

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Patient Name: ___________________________________ Date: ______________

THERAPIST NOTICE

I am being advised by this document that my insurance will only pay for service(s) that it determines to be “medically necessary” and that are covered benefits. If my insurance company determines that a particular service(s), although it would be otherwise covered, is not medically necessary, nor a covered benefit, they will deny payment for that service(s). If any type of service from From the Heart Physical Therapy is not covered, I understand that From the Heart Physical Therapy will bill me for all services rendered and not paid by my insurance company and that I will be held personally and fully responsible for payment of all services rendered at From the Heart Physical Therapy.

Patient Signature: ___________________________________

BENEFIT AGREEMENT

I have been notified by my physical therapist that he/she believes that my insurance carrier is likely to pay From the Heart Physical Therapy for my medically necessary services; however, if my insurance company denies payment, I agree to be held personally and fully responsible for payment of all services rendered at From the Heart Physical Therapy.

Patient Signature: ___________________________________

WAIVER

I acknowledge that if my insurance does not show me eligible for coverage with the physical therapist I am seeing today at From the Heart Physical Therapy, for any reason including enrollment in Home Health Services, that I will be responsible for pay all my medical services “in full”.

Patient Signature: ___________________________________

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A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____________ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**___________ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Outpatient Physical Therapy Services @ From The Heart Physical Therapy, INC.	**A.** If you have exhausted your $2010.00 Physical Therapy Cap OR **B.** If you have exhausted $3700 Physical Therapy Cap using KX modifier	$150.00-$200.00 per visit

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____________ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** ____________listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** ____________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.** ____________ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information: This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or
Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (03/11) Form Approved OMB No. 0938-0566

PATIENT MEDICATION LOG

Patient Name: ______________________________ **Date:** ____________

Please provide an accurate record of any/all medications that you are currently taking:

Medication Name	Dosage	Frequency
(1) ______________________	________	________
(2) ______________________	________	________
(3) ______________________	________	________
(4) ______________________	________	________
(5) ______________________	________	________
(6) ______________________	________	________
(7) ______________________	________	________
(8) ______________________	________	________
(9) ______________________	________	________
(10) ______________________	________	________
(11) ______________________	________	________
(12) ______________________	________	________
(13) ______________________	________	________
(14) ______________________	________	________
(15) ______________________	________	________

To the best of my knowledge, I certify that the above information is true and correct. It is my responsibility to inform From The Heart Physical Therapy of any changes to this information.

Patient Signature: ______________________________

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HIPAA PRIVACY AUTHORIZATION FORM

**Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

Patient Name: ____ **Date:** ____________

1. Authorization: I authorize **From The Heart Physical Therapy** to use and disclose the protected health information described below to ____ (individual or entity seeking the information).

2. Effective Period: This authorization for release of information covers the period of healthcare from:
   a.□ ______________to _______________.
   OR
   b.□ all past, present, and future periods.

3. Extent of Authorization:
   a.□ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
   OR
   b.□ I authorize the release of my complete health record with the exception of the following information:
   □ Mental health records □ Communicable diseases (including HIV and AIDS)
   □ Alcohol/drug abuse treatment □ Other (please specify): _______________________________

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until __________________ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative: ____

Printed name of personal representative and his or her relationship to patient:

____

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Pain Disability Index

Name: ____ **Date:**____________________

Family/Home Responsibilities: It includes chores or duties performed around the house and errands or favors for family members (ex. driving the children to school).

No Disability _0 1 2 3 4 5 6 7 8 9 _10 Worst disability

Recreation: Hobbies, sports, and similar leisure time activities.

No Disability _0 1 2 3 4 5 6 7 8 9 _10 Worst disability

Social Activity: Activities that involve participation with friends and acquaintances other than family members. It includes parties, theater, concert, dining out, and other social functions.

No Disability _0 1 2 3 4 5 6 7 8 9 _10 Worst disability

Occupation: Activities that are a part of or directly related to one's job. This includes nonpaying jobs as well, such as that of a housewife or volunteer worker.

No Disability _0 1 2 3 4 5 6 7 8 9 _10 Worst disability

Sexual Behavior: Refers to the frequency and quality of one's sex life.

No Disability _0 1 2 3 4 5 6 7 8 9 _10 Worst disability

Self-Care: Refers to bathing and dressing

No Disability _0 1 2 3 4 5 6 7 8 9 _10 Worst disability

Life-Support Activity: Eating, sleeping, and breathing.

No Disability _0 1 2 3 4 5 6 7 8 9 _10 Worst disability

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