From The Heart™
PHYSICAL THERAPY

New Patient Registration

Patient Name		DOB	SEX ☐Male ☐Female	Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced
Residence Address		City	State	Zip Code
Home Phone #	Cell Phone #	Work Phone #	Email	

If minor, parent or guardian's name	Social Security #	Driver's License #	Occupation
Name of Employer	Address		Phone #
Insurance Company Name	Address		Phone #
			Fax #
Subscriber's Name	Policy #	Certificate #	Group #
Secondary insurance Company Name	Address		Phone #
Subscriber's Name	Policy #	Certificate #	Group #
Physician's Name	Address		Phone # Fax #
Emergency contact	Relationship		Phone #

Patient Signature: _____ **Date:** _____

P. (818) 609-9035 F. (818) 775-9135 ▪ info@fromtheheartphysicaltherapy.com
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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 _____)

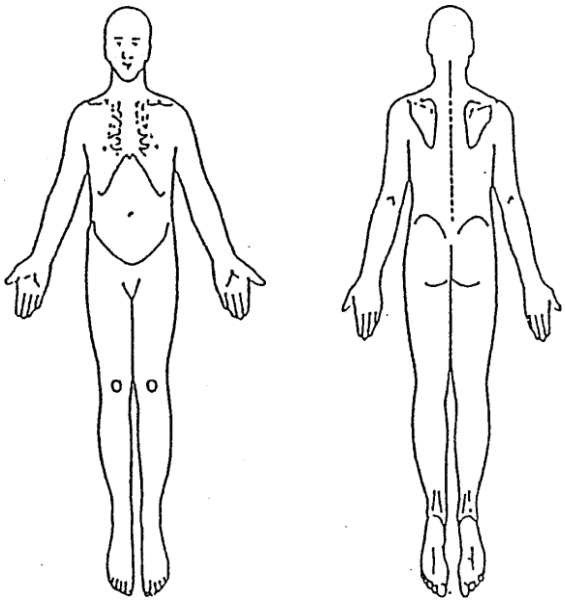
2. What is your occupation and describe the physical demands: _____

_____

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)	_____	_____	_____
(2)	_____	_____	_____
(3)	_____	_____	_____
(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. 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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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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