Costa Mesa Physical Therapy

Patient Information:

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ SSN: _____ Gender: M/F Marital Status: _____

Email: _____

Emergency Contact:

Last Name: _____ First Name: _____

Phone: _____ Relationship:_____

Employer:

Name: _____ Phone: _____

Address: _____City: _____ State: _____ Zip: _____

Insurance, Financial, and Office Policy:

ASSIGNMENT OF INSURANCE BENEFITS:

I, HEREBY, AUTHORIZE Costa Mesa Physical Therapy (CMPT), to furnish information to insurance companies concerning my treatment. I, hereby, assign all payments for services rendered, to Health Works Physical Therapy, Inc.(HWPT), DBA Costa Mesa Physical Therapy (CMPT). **Initial Here:_____**

WORKERS' COMPENSATION CLAIMS:

If you claim Workers' Compensation benefits and are subsequently denied such benefits for any reason, you will be held responsible for the total charge amount for service rendered, to HWPT dba CMPT. **Initial Here:_____**

CANCELLATION AND NO-SHOW:

We require 24 hours' notice in the event of cancellation. **Failure to provide such notice will result in a charge of $35 for a physical therapy visit missed**. This charge will not be covered by insurance, but will have to be paid by you personally prior to receiving additional treatment. **Initial Here: _____**

As a courtesy to our patients, we will contact your health insurance and Medicare to obtain authorization and verification of coverage, then will provide you with an ***estimate*** of anticipated out-of-pocket costs that you may expect to incur during your treatment at CMPT. We will also bill your insurance company on your behalf.

We strongly encourage you to contact your insurance company at the start of your treatment to verify your insurance coverage and benefit estimates.

We require that arrangements for payment of your estimated share of your bill be made today. If your insurance company does not remit payment for services within 60 days, we reserve the right to bill you directly for the entire cost of the services. In the event that your insurance company requests a refund of their portion of the payments made to HWPT/CMPT, then you may be responsible for payment of the amount refunded. If, for any reason, payments are made directly to you by your insurance company for the services billed by HWPT, you will promptly remit such payment to HWPT. Should formal collections procedures become necessary, you will be responsible for any additional costs incurred due to such collections actions. HWPT assumes no liability for any errors made by your insurance company in determination of your actual benefits. These benefits have been reviewed with you and you agree to pay your portion of the bill.

Will pay each visit **Will pay weekly in advance**

Remaining Deductible: $_____ COPAY/CO-INS: $_____ CASH AMT: $_____

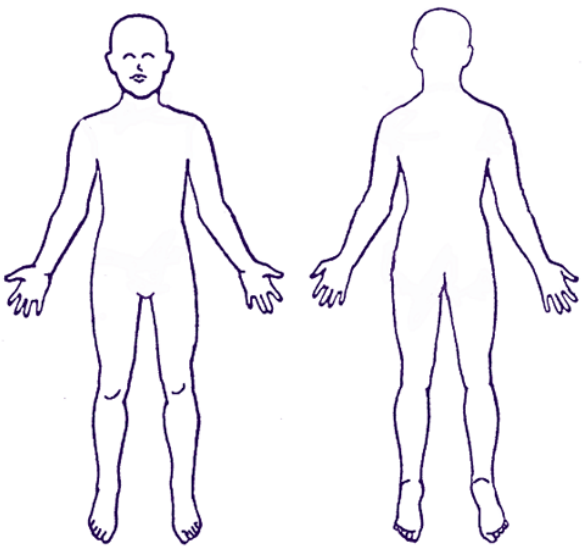
I understand that I am Financially responsible for any balance due. **Initial Here: _____**

Type of Injury_____

Type of Surgery & Date_____

Previous treatments for this condition_____

_____



Have you received physical therapy for this condition? Yes/No
Have you received Home Health Care this year? Yes/No
Have you had an imaging performed related to this condition:

- ☐ X-Ray
- ☐ MRI
- ☐ CT Scan
- ☐ Ultrasound
- ☐ Doppler

Describe the type of pain you are having: Sharp - Burning - Aching - Tingling - Numbness - Other_____
Rate your pain (0=no pain, 10=severe): 0 1 2 3 4 5 6 7 8 9 10
Have you recently noted:

- ☐ Weight Gain/Loss
- ☐ Weakness:_____
- ☐ Pregnant
- ☐ Pain at night
- ☐ Nausea/Vomiting
- ☐ Fever/Chills/Sweats
- ☐ Headaches
- ☐ Cramps in legs
- ☐ Fatigue
- ☐ Numbness/Tingling:
- ☐ Change in vision or hearing
- ☐ Insomnia
- ☐ Pain after eating

Do you have or have you ever had any of the following?

- ☐ Surgeries
- ☐ Sprains/Strains
- ☐ Heart Problems/Pacemaker
- ☐ Blood Clots
- ☐ Bruising/Bleeding
- ☐ Indigestion/Heartburn
- ☐ Loss of Consciousness
- ☐ Diabetes
- ☐ Cancer
- ☐ Asthma
- ☐ Leg Swelling
- ☐ Fainting
- ☐ Fractures
- ☐ Irregular Blood Pressure
- ☐ Car Accident
- ☐ Lung Disease
- ☐ Urinary Problems
- ☐ Allergies
- ☐ Any previous injuries that may affect current care_____

Explain any items indicated above_____

_____

Are you currently taking any medication? If yes please list_____

_____

What do you hope to get out of physical therapy? Goals?_____

CONSENT FOR CARE AND TREATMENT:

Your Physical Therapist will complete an evaluation by interview and examination, after which your individual treatment program will be designed. A variety of treatment techniques may be used. I, the undersigned, do hereby agree and give my consent, for CMPT to furnish and provide physical therapy treatment considered necessary and proper in the professional evaluation and care of my condition.

CONSENT FOR TREATMENT OF A MINOR

As parent and/or legal guardian, I authorize CMPT to treat the minor as a physical therapy patient, even when I am not present. Parent/Guardian Name:_____ **Parent/Guardian Initials:** _____

I authorize release of information requested by my insurance plan for payment.
I authorize release of information about my appointment/treatment via **email, phone/voicemail, and/or text**
To: (if anyone besides yourself)_____
I hereby acknowledge that I have received a copy of the **Notice of Privacy Practices.**

I agree to comply with the terms and conditions as outlined on the Patient Registration form.
(You have the right to refuse to sign this acknowledgment if you so choose.)

Signature: _____ Date: _____