Tracy Blum Physical Therapy, Inc

NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION						
Last Name:			First Name:			Middle Initial:
Date of Birth: / /	Age:	Sex: ❑ M ❑ F	Social Security #: / /	Marital Status (circle one) Single / Mar / Child / Other		
Street Address:			City:	State:	ZIP Code:	
Home Phone: ( )			Work: ( )	Cell: ( )		
Preferred no. to use for calls and messages: ❑ Home ❑ Work ❑ Cell ❑ Email Email address:						
Employer:			Occupation:			
Is this a work related injury? ❑ Yes ❑ No Date of injury:			Is your visit today related to an automotive accident? ❑ Yes ❑ No Date of Accident:			

IN CASE OF EMERGENCY
Name: Relationship: Phone: ( )

INSURANCE INFORMATION PLEASE READ INSURANCE POLICY ON THE NEXT PAGE	
Insurance Carrier:	Customer Service no.:
Member ID or Policy Number:	Group or Claim Number:
Name of Insured:	Relationship:
Claims Mailing address: (Include Adjuster Name if applicable)	
Employer:	Employer phone no.:
Date of Birth:	Social Security no.:

Signature of the Insured:	
Person Responsible for Bills: Bills with your balance will be sent to the insured, unless noted otherwise.	Address:

I certify that the information is true and correct to the best of my knowledge. I will notify Tracy Blum Physical Therapy, Inc of any changes in the status of the above information.

Patient/Parent Signature:	Date

Tracy Blum Physical Therapy, Inc

CLINIC POLICIES AND CONSENT

CANCELLATION POLICY

We require a 24 hours notice cancellation; a message machine is available 24 hours a day for your convenience. In the event 24 hours notice is not given, you will be charged for the full session. If less than 24 hours notice is given, due to an emergency, it will be left to the clinic's discretion on whether to waive the fee or charge a partial fee of $75.00. This charge is your responsibility and will not be paid by your insurance company.

PAYMENT POLICY

Payment is due in full at the time of service unless prior arrangements have been made.

Checks should be made out to Tracy Blum Physical Therapy, Inc

INSURANCE POLICY

Tracy Blum Physical Therapy, Inc does not participate in any insurance provider network.

If you would like our office to bill your insurance for your visits, please read and sign this policy:

1. Tracy Blum Physical Therapy, Inc will bill my insurance company for services at this office.
2. I understand that Tracy Blum Physical Therapy, Inc is not a contracted provider with any heath insurance. I assume full responsibility for any and all co-pays, co-insurance, deductibles and balances assigned to me by my insurance company.
3. Tracy Blum Physical Therapy, Inc reserves the right to discontinue billing your insurance company for any reason and at any time, should the company fail to pay for services.
4. I agree to inform Tracy Blum Physical Therapy, Inc of any changes in my insurance coverage and/or contact information.
5. I authorize my insurance benefits be paid directly to Tracy Blum Physical Therapy, Inc.
6. I authorize Tracy Blum Physical Therapy, Inc. to release any information pertinent to my case to any insurance company, adjustor, attorney or other persons entitled to said information who requests such information in writing.

Our services are covered by most insurance PPO/POS health insurance plans. It is your responsibility to communicate with your insurance company regarding coverage and benefits for physical therapy out of network.

Although you have requested Tracy Blum Physical Therapy, Inc to bill your insurance on your behalf, please understand that you are responsible for payment on your account regardless of the status of your insurance claims.

I have read, understand and agree to the terms of the above policies for Tracy Blum Physical Therapy, Inc.

____

Patient Signature Date

____

Parent/Guardian Signature (if minor)

CONSENT TO TREAT

My signature below is my consent to receive and pay for physical therapy treatment at Tracy Blum Physical Therapy, Inc.

____

Patient Signature Date

____

Parent/Guardian Signature (if minor)

NOTICE OF PRIVACY PRACTICES

Effective: April 14, 2003

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully:

Understanding your health record/information:

When receiving physical therapy services from Tracy Blum Physical Therapy, Inc., a record is made of your treatment. This record contains your symptoms, diagnoses, examinations, assessments, evaluation and your treatment plan. It also contains daily treatment notes and progress notes. This record is referred to as your medical record and serves as a:

- Basis for planning your care and treatment
- Means of communication among the health professionals who contribute to your care
- Legal document describing the care you receive
- Means by which services can be verified for billing purposes
- A tool for educating physical therapy professionals
- A source of data for facility planning
- A tool with which the quality and outcome of care and services given can be evaluated.

Our pledge regarding medical information:
We understand the medical information about you is personal. We are committed to protecting this information. We create a record of care and services you receive. This record is needed to provide you with quality care and to comply with certain legal requirements. This notice applies to the records for your treatment.

How we may use and disclose your medical information:

1. **For treatment:** We may use medical information about you to provide you with treatment. We may disclose this information to your doctors, or other personnel who are involved in your treatment.

2. **For payment**: We may disclose medical information about you so that the treatment you receive may be billed to and payment may be collected from insurance or other benefits that you may be entitled to.

3. **Review for quality care**: we may disclose medical information about you for internal quality check to make sure all of our patients receive quality care.

4. **As required by Law:** We will disclose medical information about you when required to do so by federal, state or local law.

5. **Lawsuits and Disputes**: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

I ____ understand the information above and acknowledge that I
Print Patient Name
have received a copy of Tracy Blum Physical Therapy, Inc. Notice of Privacy Practices. This notice describes how Tracy Blum Physical Therapy, Inc. may use or disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

____ __________________________

Signature of patient or Personal Representative Date

____

Relationship to Patient

Pain History:

Main Complain:____

____

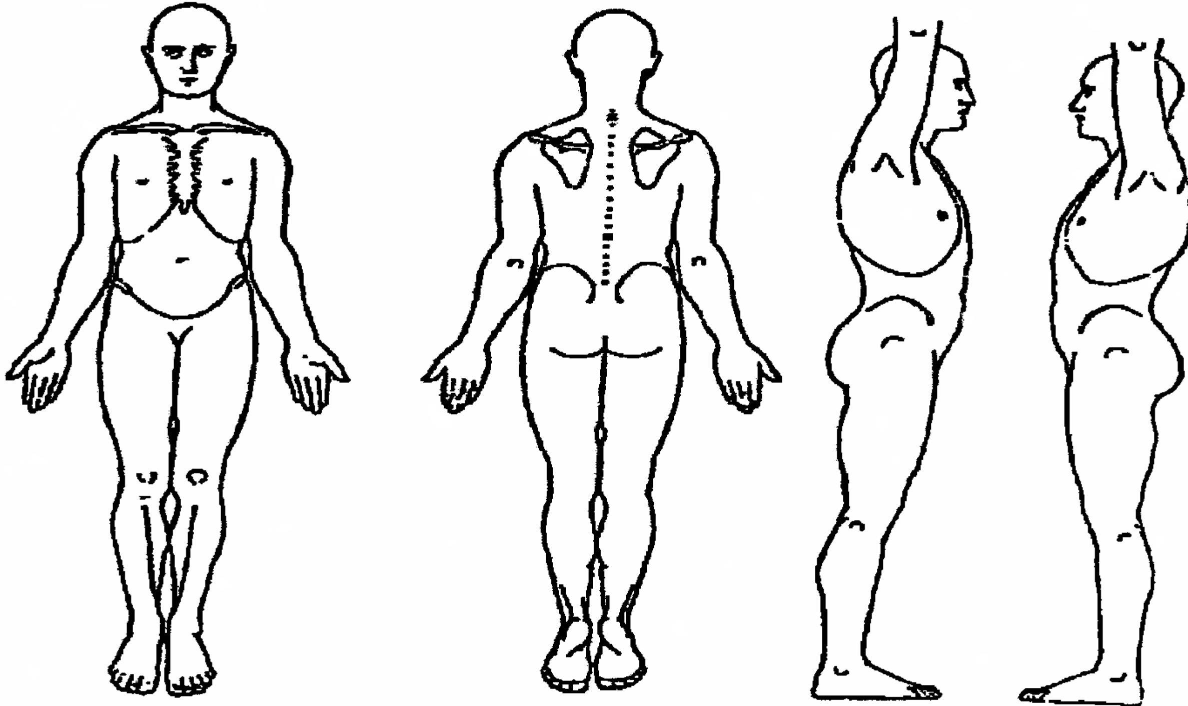
____

Date of onset:_________________________

Secondary to **(circle one):** Illness Accident Work Other:____

Location of Pain:____

Directions: On the body diagrams below, please mark the areas of your pain.



How often do you have pain? **(Circle one)** Constantly Intermittently

How would you describe your pain? **(Circle as many as necessary)**
Aching Throbbing Sharp Shooting Burning Stabbing Other:_________________________________

On a scale of 0-10, if zero is NO pain at all and ten is THE MOST unbearable pain ever, what is your pain score?

Without Activity:_________ With Activity:__________ On the Average:__________

What make your pain better? (e.g. Heat, Cold, Positioning, Medication, etc)____

____

____

What makes your pain worse? (e.g. Bending Forward, Standing, Sitting, Walking, etc)______________________________________

____

____

What medications are you currently taking? (please include any over the counter medicines as well)

Name: How many per day: Effect (0= no help, 10= very helpful):

What medications have you tried for pain in the past?

Name: How many per day: Effect (0= no help, 10= very helpful):

Please list all of your Allergies:______________________________

____

Please list all other treatments you have had (e.g. Physical Therapy, Injections, Acupuncture, etc.):________________

____

____

Medical History:

What Illnesses do you have? (Diabetes, Heart Disease, Liver Disease, Seizures, etc.) ____________________

____

____

____

What Surgeries have you had? (please provide the date)______________________________

____

____

____

What Illnesses run in your family?______________________________

____

Social History:

How much do you smoke? ________________ **How long?**________________

How much do you drink? ________________ **How long?**________________

Are you currently involved in litigation or a lawsuit? If yes, please explain:____________________

____

____

Review of Systems: (Please circle as many as needed and provide explanation if needed)

General: Change in Weight, Appetite, Sleep, Taste, Smell, Fatigue, Fever

____

Skin: Rash, Itching

____

Head and Neck: Hearing Impairment, Dizziness, Balance Problems, Vision or Eye Problems, Nose Bleeds, Hoarseness, Mouth Sores, Difficulty Swallowing

____

Breast: Any abnormal enlargements or tenderness

____

Lungs: Chronic Cough, Emphysema, Tuberculosis, Bronchitis

____

Cardiovascular: High Blood Pressure, Chest Pain, Heart Attack, Shortness of Breath, Murmurs, Congestive Heart Failure, Deep Vein Thrombosis (DVT)

____

Gastrointestinal: Stomach Ulcers, Stomach Bleeds, Heart Burn, Rectal Bleed, Hiatal Hernia, Pancreatitis, Diarrhea, Constipation

____

Urinary Tracy: Kidney Stones, Kidney Infections, Painful Urination, Incontinence, Bleeding

____

Reproductive: Sexually Transmitted Diseases, Bleeding, Impotence

____

Endocrine: Thyroid Disease, Diabetes, Pituitary or other gland or hormonal disease

____

Blood & Lymphatics: Lymphoma, Bleeding problems

____

Musculoskeletal: Osteoarthritis, Rheumatoid Arthritis, Back Pain, Joint Pain, Muscle Disorder

____

Nervous: Fainting, Headache, Seizure, Memory Loss, Dizziness, Numbness

____

Psychiatric History: Depression, Anxiety

____

This is your Patient Copy.

Tracy Blum Physical Therapy, Inc

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFOMRATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this notice, please contact our privacy officer listed below.

How this physical therapy facility may use or disclose your health information.

For treatment: We may use medical information about you to provide you with treatment. We may disclose this information to your doctors, or other personnel who are involved in your treatment.

For payment: We may disclose medical information about you so that the treatment you receive may be billed to and payment may be collected from insurance or other benefits that you may be entitled to.

Review for quality care: we may disclose medical information about you for internal quality check to make sure all of our patients receive quality care.

As required by Law: We will disclose medical information about you when required to do so by federal, state or local law.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

In any other situation, our policy is to obtain your written authorization to release your information. You may later revoke the authorization to stop further disclosures at any time. We may change our policy at any time. When changes are made, a new Policy of Privacy Practices will be provided to you on your next visit. You may also request an updated copy at any time.

Patients' Individual Rights

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes. You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or emergency circumstances. Will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

Concerns and Complaints

If you are concerned that we may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact us our privacy office listed below. You may also send a written complaint to the U.S. Dept. of Health and Human Services. For further information on our privacy practices or if you have a complaint, please contact the following person:

Privacy Officer: Miriam Daboub
Phone: 949-648-7769
Email: mdbilling1@gmail.com