FUNCTIONAL PHYSICAL THERAPY, INC
150 N. SANTA ANITA AVE. SUITE 210
ARCADIA, CALIFORNIA 91006
PHONE: (626) 446-3862 FAX: (626) 446-3860

PATIENT NAME: _____

Consent for Care and Treatment

I, the undersigned, hereby agree and give my consent for above named practice to furnish care and treatment considered necessary and proper in treating my condition.

Authorization for Signature on File and Release of Information

I, the undersigned, hereby authorize the office of above named practice to affix my name to any and all claims or documents as related to any and all health benefits due me. I authorize the release of any information relating to my health care claims. A photostatted copy of this authorization shall be as valid as an original.

Authorization for Assignment of Benefits

I, the undersigned, hereby assign all medical benefits, to which I am entitled, to the office of above named practice, and I shall be financially responsible for any unpaid balance. In the event payment is made directly to me for services rendered by this office, I recognize the obligation to promptly remit payment to this office. I hereby authorize and instruct my insurance company to pay by check and mail directly to above named practice.

Financial Responsibility

I, the undersigned, understand and agree that if it becomes necessary to commence legal action, I am responsible for all costs of collecting moneys owed including court costs, collection agency fees and attorney fees, in addition to my outstanding account balance. I further understand that balances over 60 days will be subject to a 1.5% finance charge, for which I am personally liable.

Cancellation Policy

Specific time is reserved for you when you schedule an appointment. If you cannot keep your scheduled appointment, please give us at least 24 hours notice so that we may reschedule your appointment and offer the reserved time to another patient. There will be a charge of $50.00 for NO SHOW appointments or cancellations with less than 24-hour notification. I, the undersigned, understand that I will be personally responsible for any cancellation fees.

I have read and fully understand all of the above information and hereby agree to comply as outlined above.

_____ _____

Patient or Guardian Signature Date

FUNCTIONAL PHYSICAL THERAPY, INC.
PATIENT REGISTRATION FORM

Date of First Visit _____ Date of Injury/Onset/Surgery: _____

Patient's Name: _____ Date of Birth: _____

Social Security #: _____ Marital Status: S M D W DL#: _____

Address: _____ Apt #:_____

City: _____ State: _____ Zip Code: _____

Sex: Male Female Type of Accident: Auto Work Other Date of Accident:_____

Home Phone #:_____ Work Phone #:_____

Cell Phone #: _____ Email Address: _____

Employer Name: _____

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

In case of emergency: _____ Phone #: _____ Relationship: _____

Have you had PT, OT, Speech, Chiro, Accupuncture this year? _____ How many visits? _____

Referring Physician: _____ Phone #: _____

Date of last MD Visit: _____ Diagnosis: _____

Prescription Frequency & Duration: _____

Referring Attorney: _____ Phone #: _____

Attorney Address: _____

City, State, Zip: _____

PRIMARY INSURANCE INFORMATION

Insurance Carrier: _____ Phone #: _____

Insured Name: _____ ID #:_____

Insured Date of Birth: _____ Insured Social Security Number: _____

Group #: _____ Policy #:_____ Claim #: _____

Is this Plan an Individual or Group Plan: _____

Adjustor Name: _____ Phone #: _____

SECONDARY INSURANCE INFORMATION

Insurance Carrier: _____ Phone #: _____

Insured Name: _____ ID #:_____

Insured Date of Birth: _____ Insured Social Security Number:_____

Group #: _____ Policy #:_____ Claim #: _____

FUNCTIONAL PHYSICAL THERAPY, INC
PATIENT HISTORY FORM

Name:_____ Gender:_____ Date of Birth:_____

Do you now have, or have ever had, any of the following (please circle one)?

Diabetes	Yes	No	Allergies	Yes	No
High Blood Pressure	Yes	No	Previous Surgery	Yes	No
Pacemaker	Yes	No	Seizures	Yes	No
Chronic Headaches	Yes	No	Metal Implants	Yes	No
Liver / Kidney Conditions	Yes	No	Dizziness	Yes	No
Nervous Disorders	Yes	No	Cancer	Yes	No
Bone Disease / Fractures	Yes	No	Osteoporosis	Yes	No
Bowel / Bladder Conditions	Yes	No	Anemia	Yes	No
Breathing Conditions	Yes	No	Depression	Yes	No
Circulatory Disease	Yes	No	Glaucoma	Yes	No
Heart Conditions	Yes	No	Corneal Implants	Yes	No
Stroke / CVA	Yes	No	Smoker	Yes	No
Thyroid Conditions	Yes	No	Currently?	Yes	No
Hernia	Yes	No	Other illness	Yes	No

If **YES** to any of the above, please: explain, give dates, and appropriate details:

_____

_____

_____

_____

Are you currently pregnant (please circle one)? Yes No N/A

List any medications you are currently taking:

_____

_____

Have you ever had physical therapy treatments for this current problem before (please circle one)? Yes No

If **YES**, indicate where, when, and was the treatment effective:

_____

_____

_____ _____

Patient's Signature Date

FUNCTIONAL PHYSICAL THERAPY, INC
DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Patient Name: _____

Patient Signature: _____

Date: _____

PATIENT INFORMATION ACKNOWLEDGMENT FORM

COMPANY NAME: _____

I have read and fully understand above named practice‘s Notice of Information Practices. I understand that above named practice may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that above named practice will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in above named practice‘s Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____
Patient Name

_____
Signature

_____

Date

I also authorize above named practice to use my protected health information for targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

_____
Patient Name

_____
Signature

_____
Date