Date:_____

PT WORKS

experience effective physical therapy

PATIENT REGISTRATION FORM **Sched**_____

Patient Name_____**DOB**____/____/___**Physician**_____
Last **First** **MI**

Address _____
Street Address City State Zip Code

Home Phone _____ O **Work Phone or** O **Cell Phone** _____

Employer_____

Email:_____**Receive appointment reminders by email? Yes No**

Have you received physical therapy this calendar year? Yes No If yes, how many visits?_____
Are you receiving any type of HOME therapy or treatment? Yes No

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Insurance Information

Primary Insurance _____ **Ins. Phone**_____

Subscriber _____**Subscriber Employer**_____

Relationship to Patient_____**Subscriber DOB**____/____/_____

Address _____ **City/State/Zip**_____

Policy/ID# _____**Group**_____**Deductible**_____**Cov%**_____
Visit Limit_____ **Pt.Cost/visit**_____

Contact In Case of an Emergency

Name_____**Relationship**_____**PH.( )**_____

_____**PAYMENT POLICY: I understand that the deductible and/or co-payment is due at the time of treatment. PT Works accepts cash, personal checks or major credit cards for payment. As a courtesy PT Works will bill my insurance carrier for services rendered, and I am responsible for all co-payments, deductible and any amounts not covered by my insurance company. After your deductible of _____ has been met, we estimate your co-pay will be _____ per visit.**

_____**I UNDERSTAND THE AMOUNT COVERED BY MY INSURANCE COMPANY AND THE OUT-OF–POCKET COST TO ME.**

_____**CONSENT FOR TREATMENT: I hereby consent to and authorize all therapy treatments, which in conjunction with the judgments of my attending physician, may be considered necessary and/or advisable for the diagnosis and/or treatment of the patient named above at PT Works.**

_____**CANCELLATION POLICY: In order to avoid a $50.00 cancellation fee, I must cancel my appointment twenty-four hours in advance. (This cannot be billed to your insurance).**

_____**AUTHORIZATION TO RELEASE MEDICAL RECORDS AND INFORMATION: I hereby authorize the release of any medical or other information necessary to process claims. I also request payment of government benefits either to myself or to the party who accepts assignment.**

Patient Signature:_____ **Date:**_____
(Parent/Legal Guardian must sign if patient is under 18 years of age)

794 Altos Oaks Drive, Los Altos, CA 94024
(650) 947-9646 fax (650) 947-9566

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PT WORKS Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At PT WORKS, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, we will send regular progress notes to your referring doctor.

We may use or disclose your health information for payment of your services. For example, we may send your evaluation and daily charts notes as requested, to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may call to make or change appointments.

We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy your health information, with a few exceptions. Please give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Please give us a written statement requesting the changes you desire. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.
However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer, Jennifer Vuong at (650) 947-9646.

This notice goes into effect as of September 1, 2009.

Acknowledgement
I have received a copy of the PT WORKS Notice of Privacy Practices. Date_____

Signed _____ **Print Name** _____

If signing as a parent or guardian, please note the name of the patient_____

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