

# ActivBody Physical Therapy

## Patient Registration Form— *Shaded Areas, Office Only*

Date: \_\_\_\_\_

Primary Insurance: Medicare <input type="checkbox"/> Group Health <input type="checkbox"/> Workers Comp <input type="checkbox"/> Lien <input type="checkbox"/> Other _____				Secondary Insurance: Medicare <input type="checkbox"/> Group Health <input type="checkbox"/> Workers Comp <input type="checkbox"/> Lien <input type="checkbox"/> Other _____										
<input type="checkbox"/> New Patient			<input type="checkbox"/> Re-Start			<input type="checkbox"/> New Diagnosis			<input type="checkbox"/> New Insurance			PTPN <input type="checkbox"/> Yes <input type="checkbox"/> No		
Patient #		Title		Patient Name (Last, First, Middle Initial)										
Address						City/State/Zip								
Home Phone				Work Phone				Cell Phone						
Social Security #			DOB		Gender		Driver's License #		Insurance Type <i>PPO, HMO, Medicare, etc</i>		Email			
Referring Physician				Referring NPI (10 digits)			Referring Physician Phone#			Treating Therapist				
Patient Status <input type="checkbox"/> Active <input type="checkbox"/> SFA		Primary location <b>CLINIC</b>			Marital Status			Student Y <input type="checkbox"/> N <input type="checkbox"/>		Employment Status				
Occupation				Employer				Employer Phone #						
Address						City/State/Zip								

**Are you currently receiving healthcare service through a Home Health Agency (HHA)?**  Yes  No

If yes, please provide name and phone number of the HHA. \_\_\_\_\_

Emergency Contact (Name)			Home Phone			Work Phone		
Address			City/State/Zip			Relationship to Patient		

### Financially Responsible Party Other than Patient

Name (First, Middle Initial, Last)				Relationship to Patient			
Address				City/State/Zip			
Home Phone		Work Phone		Email Address			
Social Security #		DOB	Gender <input type="checkbox"/> M <input type="checkbox"/> F		Driver's License #		

### Injury Information

Is condition surgery related? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Surgery		Surgical Procedure			
Is condition accident related? <input type="checkbox"/> Yes <input type="checkbox"/> No		Was an automobile involved? <input type="checkbox"/> Yes <input type="checkbox"/> No			Date of Accident		
Describe Accident/Injury/Illness							
Were you injured on the job? <input type="checkbox"/> Yes <input type="checkbox"/> No			Date of Injury			Are you currently working? <input type="checkbox"/> Yes <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> No	
Name of employer at time of accident				City, State, Zip Code			
Is litigation (lawsuit) involved? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of Attorney			Phone #		

### -Office Use Only-

Diagnosis:				ICD-10 Code:			
Diagnosis:				ICD-10 Code:			

## Insurance Information

Were benefits and authorization verified?  Yes  No

<b>Primary Insurance</b>		In- network <input type="checkbox"/> Out-of-network <input type="checkbox"/>		Pre-Certification <input type="checkbox"/> Yes <input type="checkbox"/> No		Visits per Year	
Claims Mailing Address			City, State, Zip Code				
Subscriber Name			Date of Birth		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to Patient	
ID Card # (including alpha prefix)			Group #		Authorization #		
Claim #		Effective Date	Coverage%	Co-Ins%	Co-Pay by Specialty \$		Visits Remaining
Deductible Start Amount \$		Deductible Remaining Amount \$			Pre-Certification Phone #		
Benefits Verified By		Date	Spoke to			Ins. Customer Service Phone #	

<b>Secondary Insurance</b>		In- network <input type="checkbox"/> Out-of-network <input type="checkbox"/>					
Claims Mailing Address			City, State, Zip Code				
Subscriber Name			Date of Birth		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to Patient	
ID Card #(including alpha prefix)			Group #		Authorization #		
Claim #		Effective Date	Coverage%	Co-Ins%	Co-Pay \$ \$	Pre-Certification <input type="checkbox"/> Yes <input type="checkbox"/> No	Visits per Year
Deductible Start Amount \$		Deductible Remaining Amount \$			Pre-Certification Phone #		
Benefits Verified By		Date	Spoke to			Ins. Customer Service Phone #	

The above description is a quote of your insurance(s) benefits. We assume no liability for any errors made by your insurance carrier(s) in this quotation. It is your responsibility to clarify any discrepancies in eligibility, benefits and/or authorization and inform our clinic immediately. We have reviewed these benefits with you. You understand and agree to pay any balance remaining after your insurance carrier(s) has paid its portion of the charges.

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Patient Initials      Date      Front Office      Date

### ASSIGNMENT OF INSURANCE BENEFITS

1. The undersigned agrees, whether signing as agent or patient, and it hereby individually obligated to pay for services rendered to the patient in accordance with the regular rates and terms of the company, which are not reimbursed by third parties. The undersigned further agrees to bear legal fees and collection expenses, which may be incurred by the company, in collection of payment on the amount, if that amount becomes delinquent.
2. The undersigned hereby authorizes treatment by ActivBody Physical Therapy and assigns to ActivBody Physical Therapy and all benefits arising out of any type of insurance, which insures the patient's bill. The undersigned understands that the temporary acceptance of verified insurance coverage in lieu of payment does not release the patient from ultimate payment responsibilities.
3. The undersigned hereby authorizes ActivBody Physical Therapy to release any or all information to third parties, including but not limited to employers and insurance companies, who may be liable to the patient or ActivBody Physical Therapy for payment of charges to the patient.
4. ActivBody Physical Therapy reserves the right to modify the privacy practices outlined in the notice. The undersigned acknowledges having received a copy of the Notice of Privacy Practices for authorizes ActivBody Physical Therapy.

<i>Patient Signature:</i>		<i>Date:</i>
<i>CPM Office Use Only:</i>	<i>Entered by:</i>	<i>Date:</i>

# MEDICAL HISTORY

Have you ever had any of the following?

	YES	NO		YES	NO
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Liver Conditions	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Conditions	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Claustrophobia	<input type="checkbox"/>	<input type="checkbox"/>
Circulation Issues	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to Heat	<input type="checkbox"/>	<input type="checkbox"/>
Dizzy Spells	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to Cold	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Speech Problems	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Fracture	<input type="checkbox"/>	<input type="checkbox"/>	Metal Implants HIV/ AIDS Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant/trying to get pregnant?	<input type="checkbox"/>	<input type="checkbox"/>			
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>			

Any other conditions or illnesses?  No  Yes If yes, Please Explain: \_\_\_\_\_

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List any surgeries (Including dates) you have had: \_\_\_\_\_

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Medications you are currently taking? \_\_\_\_\_

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Have you ever had Physical Therapy?  No  Yes If yes, please list when, for what condition, and where at? \_\_\_\_\_

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**Check any other areas you would like to seek advice on:**

- Body Fat Loss
- Nutritional Supplementation
- Immune System
- Joint Health
- Cardiac Health/Cholesterol Issues
- Support Anti-Oxidants

**ActivBody Physical Therapy, Inc**  
*19531 Beach Blvd*  
*Huntington Beach, CA 92648*  
*714-960-7995, Fax: 714-960-1884*

## CONSENT FOR TREATMENT

**Consent for Physical Therapy:** *Knowing that I am suffering from a condition requiring diagnostic or medical treatment, I hereby consent to care by ActivBody PT, Inc as they may deem necessary by their judgment, under the prescription of a licensed physician. I do hereby voluntarily consent to the rendering of care for a condition requiring physical therapy services. I understand and expect that the care I receive by ActivBody, PT, Inc will meet customary standards, I do understand that medicine is not an exact science and acknowledge that diagnosis and treatment may involve risks of injury. I acknowledge that no guarantees have been made to me as a result of examination of treatment. I hereby authorize ActivBody, PT, Inc to retain any records for use, for research and for teaching purposes.*

*If I refuse treatment that is suggested for me, I will not hold ActivBody, PT, Inc or any individual responsible for any consequences resulting from my decision.*

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this **Consent for Treatment**. I understand that, by signing this Consent form, I am giving my consent to treatment and attest that I am aware and understand all of the above.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*If this Consent is signed by a personal representative on behalf of the patient, complete the following:*

Personal Representative's

Name:

\_\_\_\_\_

Relationship to Patient:

\_\_\_\_\_