# ActivBody Physical Therapy

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

| | | | | | |
|---|---|---|---|---|---|
| **Primary Insurance:** Medicare ☐ Group Health ☐ Workers Comp ☐ Lien ☐ Other ☐_____ | | | **Secondary Insurance:** Medicare ☐ Group Health ☐ Workers Comp ☐ Lien ☐ Other ☐_____ | | |
| ☐ New Patient ☐ Re-Start ☐ New Diagnosis ☐ New Insurance | | | | **PTPN** ☐ Yes ☐ 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 *PPO, HMO, Medicare, etc* | Email |
| Referring Physician | Referring NPI (10 digits) | Referring Physician Phone# | Treating Therapist | | |
| Patient Status ☐ Active ☐ SFA | Primary location CLINIC | Martial Status | Student Y ☐ N ☐ | 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 ☐M ☐F | Driver's License # |

### Injury Information

| | | | |
|---|---|---|---|
| Is condition surgery related? ☐ Yes ☐ No | Date of Surgery | Surgical Procedure | |
| Is condition accident related? ☐ Yes ☐ No | Was an automobile involved? ☐ Yes ☐ No | Date of Accident | |
| Describe Accident/Injury/Illness | | | |
| Were you injured on the job? ☐ Yes ☐ No | Date of Injury | Are you currently working? ☐ Yes ☐ Full-time ☐ Part-time ☐ No | |
| Name of employer at time of accident | City, State, Zip Code | | |
| Is litigation (lawsuit) involved? ☐ Yes ☐ 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

| **Primary Insurance** In- network ☐ Out-of-network ☐ | | | | Pre-Certification ☐Yes ☐No | Visits per Year |
|---|---|---|---|---|---|
| Claims Mailing Address | City, State, Zip Code | | | | |
| Subscriber Name | Date of Birth | Sex ☐M ☐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 # | | |

| **Secondary Insurance** In- network ☐ Out-of-network ☐ | | | | | | |
|---|---|---|---|---|---|---|
| Claims Mailing Address | City, State, Zip Code | | | | | |
| Subscriber Name | Date of Birth | Sex ☐M ☐F | Relationship to Patient | | | |
| ID Card #(including alpha prefix) | Group # | Authorization # | | | | |
| Claim # | Effective Date | Coverage% | Co-Ins% | Co-Pay $ $ | Pre-Certification ☐Yes☐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.

| | | | |
|---|---|---|---|
| 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 Therapyany 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 Therapyfor payment of charges to the patient.
4. ActivBody Physical Therapyreserves 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.

| *Patient Signature:* | | Date: |
|---|---|---|
| *CPM Office Use Only:* | *Entered by:* | *Date:* |

# MEDICAL HISTORY

**Have you ever had any of the following?**

| | YES | NO |
|---|---|---|
| High Blood Pressure | ☐ | ☐ |
| Cardiac Conditions | ☐ | ☐ |
| Heart Attack | ☐ | ☐ |
| Circulation Issues | ☐ | ☐ |
| Pacemaker | ☐ | ☐ |
| Seizures | ☐ | ☐ |
| Dizzy Spells | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Allergies | ☐ | ☐ |
| Fracture | ☐ | ☐ |
| Arthritis | ☐ | ☐ |
| Are you pregnant/trying to get pregnant? | ☐ | ☐ |
| Kidney Problems | ☐ | ☐ |

| | YES | NO |
|---|---|---|
| Liver Conditions | ☐ | ☐ |
| Cancer | ☐ | ☐ |
| Claustrophobia | ☐ | ☐ |
| Nervous Disorders | ☐ | ☐ |
| Vision Problems | ☐ | ☐ |
| Sensitivity to Heat | ☐ | ☐ |
| Sensitivity to Cold | ☐ | ☐ |
| Speech Problems | ☐ | ☐ |
| Stroke | ☐ | ☐ |
| Metal Implants | ☐ | ☐ |
| HIV/AIDS | ☐ | ☐ |
| Hepatitis | ☐ | ☐ |

Any other conditions or illnesses? ☐ No ☐ Yes If yes, please explain: _____

_____

_____

List any surgeries (including dates) you have had: _____

_____

Medications you are currently taking? _____

_____

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

_____

**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:

_____

 