ActivBody Physical Therapy

Patient Registration Form— *Shaded Areas, Office Only*

☐New Patient ☐Re-Start ☐ New Diagnosis ☐ New Insurance			Date:
Patient #	Title	Patient Name (Last, First, Middle Initial)	
Address		City/State/Zip	
Home Phone	Work Phone	Cell Phone	
DOB	Gender	Insurance Type *PPO, HMO, Medicare, etc*	Email
Referring Physician	Referring NPI (10 digits)	Referring Physician Phone#	Treating Therapist
Patient Status ☐Active ☐ SFA	Primary location ORANGE	Martial Status	Student Y ☐ N ☐	Employment Status
Occupation	Employer		Employer Phone #
How did you hear about us?			

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)	Cell Phone	Home Phone
Relationship to Patient		Work Phone

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	Prescription Required ☐ Authorization Required ☐ Frequency/Details:			
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 Therapy any 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 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:*

Name:_____ DOB: _____

Primary Care /General Doctor: _____
Date of Onset of Pain: _____ **Date of Injury:** _____ **Date of Surgery:** _____
Pain Status: ☐ New Injury ☐ Chronic Injury
What is your primary concern? _____
Pain Location: _____ **Treatment Side:** ☐ N/A ☐ Left ☐ Right

Pain Scale: 0= None 5= Moderate 10= Extreme

	0	1	2	3	4	5	6	7	8	9	10
At worst:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Current:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
At best:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Aggravating Factors: ☐ Sitting ☐ Standing ☐ Walking ☐ Lying down
☐ Stairs – up ☐ Reaching ☐Lifting ☐ Getting up from a chair

What makes it feel better? _____ **Feel worse?** _____
History of Similar Symptoms: ☐ No ☐ Yes **History of Falls in last year:** ☐ No ☐ Yes
Home Health Care: ☐ No ☐ Yes **Hospitalization in last 3 months?** ☐ No ☐ Yes

Medical History:

☐ Alzheimer's	☐ Fracture or Suspected Fracture	☐ Rheumatoid Arthritis
☐ Cardiovascular Disease	☐ High Blood Pressure	☐ Traumatic Brain Injury
☐ Cauda Equina Syndrome	☐ History of Cancer	☐ Allergies: _____
☐ CVA / Stroke	☐ Huntington's	☐ Unexplained Weight Loss
☐ Current Infection	☐ Immunosuppression	☐ Pacemaker
☐ Diabetes Mellitus Type 1	☐ Lupus	☐ Pregnant
☐ Diabetes Mellitus Type 2	☐ Muscle Dystrophy	☐ Seizures
☐ Hemophilia	☐ Osteoarthritis	☐ HIV/AIDS
	☐ Hepatitis B/C	☐ Other: _____

Diagnostics: ☐ X-Ray ☐ MRI ☐ CT Scan ☐ Myelogram ☐ Diagnostic Ultrasound
Results of Imaging: _____
Medications: ☐ See attached _____
_____
Patient Goals for Physical Therapy: _____
_____

Patient Signature _____ **Date** _____

ActivBody Physical Therapy

ActivBody Physical Therapy
Cancellation Policy

ActivBody Physical Therapy requires 24 hours cancellation notice for any appointment.

We understand life happens and you may possibly need to miss a scheduled appointment for illness or emergency. However, please be considerate and provide adequate notice if you cannot make it. When you late cancel, we are unable to give that appointment to someone else who needs our help.

Patients who late cancel or no show will be charged a fee for the missed appointment. Illnesses and emergencies are addressed on an individual basis. Please contact our office manager if you have any questions.

Fees

If you late cancel or no show, the fee will be collected at your next appointment. If no visit is scheduled, a statement will be mailed to you.

$50 for the first incident
$75 for subsequent incidents

Descriptions

Late Cancellation: Appointment is cancelled within 24 hours of scheduled appointment.
No Show: Patient does not show up for scheduled appointment.
Late Arrival: Patient arrives more than 10 minutes late.

In the event of a late arrival, our staff will try to accommodate you, depending on our schedule and their availability without reducing time with other on time appointments.

Please call the office at least 24 hours in advance (Monday appointments need to be cancelled by Friday, unless due to illness). Please call (714)998-8403 or respond to your reminder text as soon as possible.

Acknowledgement of Cancellation & No-Show Agreement

Signed: _____ Date Signed: _____

Print Name: _____ Date of Birth: _____

If Patient is a Minor

Print Name: _____ Date of Birth: _____

Office: _____

ActivBody Physical Therapy

ActivBody Physical Therapy, Inc
1860 N. Tustin Street
Orange CA 92865
(714)998-8403, Fax: (714)998-8409

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:

_____

