EVERGREEN PHYSICAL THERAPY SPECIALISTS, INC.
200 E. DEL MAR BLVD. SUITE 302, PASADENA, CA 91105

PATIENT REGISTRATION FORM

PATIENT'S NAME_____SEX: M / F

GUARDIAN (IF MINOR) _____

PATIENT'S ADDRESS_____

CITY/STATE/ZIP_____

CELL PHONE_____

HOME PHONE_____

EMAIL ADDRESS_____

☐ I would like to receive occasional emails regarding clinic news

☐ I would like to receive appointment reminders via **EMAIL, TEXT, or VOICE CALL (please circle one)**

EMERGENCY CONTACT_____

EMERGENCY PHONE_____

REFERRING PHYSICIAN_____

REFERRING PHYSICIAN PHONE_____

DIAGNOSIS_____

DATE OF INJURY/ONSET/SURGERY:_____

IF ACCIDENT: AUTO / WORK / OTHER DATE OF ACCIDENT:_____

HAVE YOU HAD PT, OT, SPEECH, CHIRO, ACCUPUNCTURE THIS YEAR? Y / N

HOW MANY VISITS _____

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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 photo 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 directly to the 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.

_____ *Notice of Privacy Practices*

I have read and fully understand the named practice's Notice of Practices. I understand that the 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 the 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 the 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.

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

Patient or Guardian Signature **Date**

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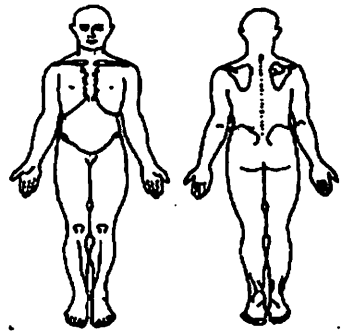
MEDICAL HISTORY

PATIENT NAME: _____ AGE: _____

*HEIGHT: _____ *WEIGHT: _____ ONSET DATE OF INJURY: _____

CONDITION/TYPE OF INJURY OR CAUSE: _____
(Is this due to an auto accident?)

TYPE OF SURGERY & DATE _____



PLEASE MARK AREA(S) OF CONCERN

HAVE YOU HAD ANY IMAGING PERFORMED:

☐X-Ray ☐CT SCAN
☐MRI ☐Ultrasound

Date of Imaging: _____

HAVE YOU RECENTLY NOTED:

☐Weight Loss/Gain	☐Nausea/Vomiting	☐Fatigue
☐Weakness	☐Fever/Chills/Sweats	☐Numbness/Tingling
☐Pregnant/IUD	☐Headaches	☐Change in Vision/ Hearing
☐Pain at Night	☐Leg Cramps when Walking	☐Insomnia

DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

☐Surgeries	☐Loss of Consciousness	☐Fractures
☐Sprains/ Strains	☐Diabetes	☐Blood Pressure Problems
☐Heart Problems	☐Cancer	☐Arthritis
☐Circulation/ Clots	☐Asthma/ Breathing Problems	☐Lung Disease
☐Fainting	☐Easy Brusing/Bleeding	☐Leg/Ankle Swelling
☐Difficulty Swallowing	☐Osteoporosis	☐Urinary Problems/Infections

EXPLAIN AND GIVE APPROXIMATE DATES FOR ANY ITEMS INDICATED ABOVE: _____

_____

*TYPE OF ALLERGIES (IF ANY) : _____

* LIST OF CURRENT MEDICATIONS	*DOSE	*FREQUENCY
_____	_____	_____
_____	_____	_____

(IF MORE SPACE IS NEEDED, PLEASE LIST ON THE BACK)

*Are you taking VITAMIN D? ☐ YES ☐ NO

*Describe the pain in the last 24 hours: DURING ACTIVITY _____ DURING REST _____
(SCALE OF 1-10) (SCALE OF 1-10)

What makes the pain better or worse? _____

*Have you had 2 or more FALLS within the last 12 months? ☐ YES ☐ NO

*Have you had at least one FALL WITH AN INJURY in the last 12 months? ☐ YES ☐ NO

What are your goals for Physical Therapy? (PLEASE USE BACK OF FORM)

X_____ _____
PATIENT OR AUTHORIZED SIGNATURE DATE

NOTICE OF PRIVACY PRACTICES

EFFECTIVE APRIL 14, 2004

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATIN ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMAION. PLEASE REVIEW IT CAREFULLY

USES AND DISCLOSES OF YOUR MEDICAL INFORMATION

FOR TREATMENT: WE MAY USE MEDICAL INFORMATION ABOUT YOU TO PROVIDE YOU WITH MEDICAL TREATMENT OR SERVICES.
FOR PAYMENTS: WE MAY USE AND DISCUSS MEDICAL INFORMATION ABOUT YOU SO THAT THE TREATMENT AND SERVICES YOU RECEIVE AT OUR PRACTICE MAY BE BILLED TO AND PAYMENT MAY BE COLLECTED FROM YOU, AN INSURANCE COMPANY, OR A THID PARTY.
FOR HEALTH CARE OPERATIONS: WE MAY USE AND DISCLOSE HEALTH INFORMAION ABOUT YOU FOR OPERATIONS OF OUR HEALTH CARE PRACTICE.
FOR INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE: WE MAY RELEASE MEDICAL INFORMATION ABOUT YOU TO A FRIEND OR FAMILY MEMBER WHO IS INVOLVED IN YOUR MEDICAL CARE.
FOR HEALTH RELATED SERVICES AND TREATMENT ALTERNATIVES: WE MAY USE AND DISCLOSE HEALTH INFORMATION TO TELL YOU ABOUT HEALTHER-RELATED SERVICES OR RECOMMEND POSSIBLE TREATMENT OPTIONS OR ALTERNATIVES THAT MAY BE OF INTEREST TO YOU.
AS REQUIRED BY LAW: WE WILL DISCUSS MEDICAL INFORMATION ABOUT YOU WHEN REQUIRED TO DO SO BY FEDERAL, STATE, OR LOCAL LAW.
TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY: WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU WHEN NECESSARY TO PREVENT A SERIOUS THREAT TO YOUR HEALTH AND SAFETY OR THE HEALTH AND SAFETY OF THE PUBLIC OR ANOTHER PERSON.
FOR MILITARY AND VETERANS: IF YOU ARE A MEMBER OF THE ARMED FORCES, WE MAY RELEASE MEDICAL INFORMATION ABOUT YOU AS REQUIRED BY MILITARY COMMAND AUTHORITIES.
FOR WORKER'S COMPENSATION: WE MAY RELEASE MEDICAL INFORMATION ABOUT YOU FOR WORKER'S COMPENSATION OR SIMILAR PROGRAMS.
FOR PUBLIC HEALTH RISKS: WE MAY DISCLOSE MEDICAL INFORMATION ABOUT YOU FOR PUBLIC HEALTH ACTIVITIES.
FOR HEALTH OVERSIGHT ACTIVITIES: WE MAY DISCLOSE MEDICAL INFORMATION TO A HEALTH OVERSIGHT AGENCY FOR ACTIVITIES AUTHORIZED BY LAW.
FOR LAWSUITS AND DISPUTES: IF YOU ARE INVOLVED IN A LAWSUIT OR A DISPUTE, WE MAY DISCLOSE MEDICAL INFORMATION ABOUT YOU IN RESPONSE TO A COURT OR ADMINISTRATIVE ORDER.
FOR LAW ENFORCEMENT: WE MAY RELEASE MEDICAL INFORMATION IF ASKED TO DO SO BY LAW ENFORCEMENT OFFICIALS.
FOR CORONERS, MEDICAL EXAMINERS, AND FUNERAL DIRECTOS: WE MAY RELEASE MEDICAL INFORMATION TO A CORONER OR MEDICAL EXAMINER.
FOR NATIONAL SECURITY AND INTELLIGENCE ACTIVITIES: WE MAY RELEASE MEDICAL INFORMATION ABOUT YOU TO AUTHORIZED FEDERAL OFFICIALS FOR INTELLIGENCE, COUNTER INTELLIGENCE, AND OTHER NATIONAL SECURITY ACTIVITIES AUTHORIZED BY LAW.
FOR PROTECTIVE SERVICES FOR THE PRESIDENT AND OTHERS: WE MAY DISCLOSE MEDICAL INFORATION ABOUT YOU TO AUTHORIZED FEDERAL OFFICALS SO THEY MAY PROVIDE PROTECTIOON TO THE PRESIDENT, OTHER AUTHERIZED PERSONS OR FOREIGN HEADS OF STATE OR CONDUCT SPECIAL INVESTIGATIONS.
FOR INMATES: IF YOU ARE AN INMATE OF A CORRECTIONAL INSTITUTION OR UNDER THE CUSTODY OF LAW ENFORCEMENT OFFICAL, WE MAY RELEASE MEDICAL INFORMATION ABOUT YOU TO THE CORRECTIONAL INSTITUTION OR LAW ENFORMENT OFFICAL.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

YOUR RIGHT TO INSPECT AND COPY: TO INSPECT AND COPY OF OUR MEDICAL INFORMATION, YOU MUST SUBMIT YOUR REQUEST IN WRITING. WE MAY DENY YOUR REQUEST TO INSPECT AND COPY, IN LIMITED CIRCUMSTANCES. IF YOU ARE DENIED ACCESS TO MEDICAL INFORMATION, YOU MAY REQUEST IN WRITING, THAT THE DENIAL BE REVIEWED.
YOUR RIGHT TO AMEND: IF YOU FEEL THAT MEDICAL INFORMATION WE HAVE ABOUT YOU IS INCORRECT OR INCOMPLETE, YOU MAY REQUEST AN AMENDMENT IN WRITING. YOUR REQUEST MAY BE DENIED IF YOU DO NOT INCLUDE A REASON TO SUPPORT THE REQUEST.
YOUR RIGHT TO AN ACCOUNTING OF DISCLOSURES: YOU HAVE THE RIGHT TO REQUEST IN WRITING, A LIST ACCOUNTING FOR MY DISCLOSURES OF YOUR MEDICAL INFORMATION WE HAVE MADE, EXCEPT FOR USES AND DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, AS PREVIOUSLEY DESCRIBED.
YOUR RIGHT TO REQUEST RESTRICTIONS: YOU HAVE THE RIGHT TO REQUEST A RESTRICTION OR LIMITATION ON THE MEDICAL INFORMATION WE USE OR DISCLOSE ABOUT YOUR FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS. ***We are not required to agree to your request.***
YOUR RIGHT TO REQUEST CONFIDENTAIL COMMUNICATION: YOU HAVE THE RIGHT TO REQUEST IN WRITING THAT WE COMMUNICATE WITH YOU ABOUT MEDICAL MATTERS IN A CERTAIN WAY OR AT A CERTAIN LOCATION.
YOUR RIGHT TO A PAPER COPY OF THIS NOTICE: YOU HAVE THE RIGHT TO A PAPER COPY OF THIS NOTICE AT ANY TIME.
CHANGES TO THIS NOTICE: WE RESERVE THE RIGH TO CHANGE THIS NOTICE, AND WILL POST THE CURRENT NOTICE IN OUR FACILITY.
COMPLAINTS: IF YOU BELIEVE YOUR PRIVACY RIGHT HAVE BEEN VIOLATED, YOU MAY FILE A COMPLAINT WITH THE PRACTIVE OR WITH THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.
OTHER USES OF MEDICAL INFORMATION: OTHER USES AND DISCLOSURES OF MEDICAL INFORMATION NOT COVERED BY THIS NOTICE OR THE LAWS THAT APPLY TO US WILL BE MADE ONLY WITH YOUR WRITTEN PERMISSION. IF YOU PROVIDE US PERMISSION TO USE OR DISCLOSE MEDICAL INFORMATION ABOUT YOU, YOU MAY RECEIVE THAT PERMISSION, IN WRITING, AT ANY TIME. IF YOU REVOKE YOUR PERMISSION, WE WILL NO LONGER USE OR DISCLOSE MEDICAL INFORMATION ABOUT YOU FOR THE REASONS COVERED BY YOUR WRITTEN AUTHORIZATION. YOU UNDERSTAND THAT WE ARE UNABLE TO TAKE BACK ANY DISCLOSURES WE HAVE ALREADY MADE WITH YOUR PERMISSION, AND THAT WE ARE REQUIRED TO RETAIN OUR RECORDS OF THE CARE THAT WE PROVIDED TO YOU.