Patient Registration

Patient's Name:_____ Date of Birth___/___/____

Patient's Address (No., Street): _____

City/State/Zip:_____

Social Security Number:_____-_____-_____

Home Phone: (_____)-_____-_____ Cell Phone: (_____)-_____-_____

Place of Work:_____ Work Phone: (_____)-_____-_____

Email Address: _____

We request your email address in order to provide you with important medical information on a timely basis. We assure you that we will NOT share your email address with any third party.

Referring Physician:_____

Primary Care Physician:_____

Office Phone:_____Office Fax:_____

In case of emergency, who may we contact?_____

Relationship to patient:_____ Cell Phone: _____

Are you currently seeing a Chiropractor? Y N
Have you received Physical Therapy this Year? Y N Date of Injury? _____

Reason for previous Physical Therapy?_____

How long have you had this pain?_____

How did you hear about us?_____

Insurance Information

Insurance Plan Name:_____ID Number:_____

Policy Group Number: _____ Name of Insured:_____

Address of the Insured:_____

HIPPA CONSENT FORM

This consent Form has been developed in response to regulations set forth under HIPPAA (Health Insurance Portability and Accountability Act). This regulation included Privacy Standards intended to protect your protected health information, included demographic information and medical information related to the past, present or future physical or mental health condition. This information includes information that is collected from you, created or received by a physician or another health care provider and information received from a health plan, an employer or a health care clearinghouse.

Under these regulations, which took effect April 14, 2003, we are asking for your consent to release information for purposes of treatment, payment and our healthcare operations. Please read the following and feel free to ask any questions that you may have.

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Maya Physical Therapy Association for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that treatment of me by the Program Therapists may be conditioned upon my consent as evidenced by my signature on the document.

I understand I have the right to request a restriction as how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Maya Physical Therapy Inc. is not required to agree to the restrictions that I may request. However, if the Maya Physical Therapy Inc. agrees to a restriction that I request, the restriction that I request, the restriction is binding on the center.

I understand I have the right to review the Maya Physical Therapy Inc. Notice of Privacy Practices prior to signing this document. This Document can be provided to me in writing and is available for my review in the waiting area of the Center and with the Front Office Staff. The Notice of Privacy practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the center. This Notice of Privacy Practices also describes my rights and the Center's duties with respect to my protected health information.

The center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Witness _____ Date _____

Attention: Patients

Maya Physical Therapy Inc.

Treatment & Cancellation Policy

Your doctor has prescribed Physical Therapy for you. Physical Therapy aims to restore the normal mechanics and functions of your injured body part. This restoration is accomplished by using a variety of treatments, and thus requires consistent attendance recommended by the Physical Therapist. In addition, for the full effect of your therapy to be realized, your treatment plan must be adhered to fully.

If you are unable to keep your appointment or are going to be late, please call our office as soon as possible. This courtesy allows us to be of service to other patients. **A charge of $25.00 may be made for missed appointments. We respectfully request that you give us 24 hours prior notice to any cancelations.**

We are extremely happy that you chose Maya Physical Therapy for your treatment. We will be committed to you and the treatment of your injury. We want to see you return to normal health as quickly as possible, which may be difficult if cancellations or failure to show problems occur.

Thank you.

Please sign below indicating you understand our policy:

_____Date: _____

Medicare regulations require us to make you aware of our billing procedures and your financial responsibility. Medicare assignment is accepted on all patients. Medicare will pay for reimbursable charges of our services at 80% of the covered amount. We will bill your co-insurance, or we will bill you, for the 20%. Outpatient therapy services are billed under the Medicare Fee Schedule.

We will be happy to bill your insurance company for services received after verification of coverage and deductible has been obtained. If for any reason your insurance company does not pay, the charges are your responsibility.

INSURANCE BENEFITS

_____ Initials	I certify that the information given by me in applying for payment under Medicare is correct.
_____ Initials	I authorize payment directly to this Center for my pending claim and/or major medical benefits otherwise payable to me, not to exceed the charges for this period of treatment. I understand that if payment is issued directly to me, it is my responsibility to forward this payment to the center.

FINANCIAL ACKNOWLEDGEMENT

_____ Initials	I understand and acknowledge my financial responsibility for a co-payment, deductibles, out of pocket or co-insurance outstanding not covered by my insurance policy.
_____ Initials	Should this account go delinquent, I agree to pay all costs of collection including collection agency fees, court costs and attorney fees.

PATIENT CONFIRMATION & CONSENT

_____ Initials	I certify that I am not currently receiving any services from a home health agency. I will notify this center prior to the initiation of an home health services on my behalf
_____ Initials	I consent to treatments and to participate in the rehabilitation program

Patients name **Patient signature** **Date**

Responsible Party if Other Than Patient **Signature** **Relationship**

Company Representative **Signature** **Date**

PHOTO/VIDEO CONSENT FORM

I hereby give **MAYA PHYSICAL THERAPY** and all employees and or agents of **MAYA PHYSICAL THERAPY** the right and permission to use and or/publish photographs/videos of me for promotional purposes advertising, publicity or display of use. I also authorize my photos /videos to be posted on social media, such as Facebook, Instagram, Twitter or office's webpage.

Initial the following:

_____Yes, you may use my photos/videos.

_____No, please do not use my photos/videos.

_____

Name of Patient or Parent/Guardian (print name)

_____

Patient or Parent/Guardian (signature)

_____

Date

MEDICAL HISTORY FORM

Name: Birthdate: _____/_____/_____ Last First M. I.	
Age:_____ Sex: ❑ M ❑ F Height:____Weight: _____	Date of injury (onset) ____/_____/____
Do you drink alcohol? ❑ No ❑ Yes	Do you smoke or chew tobacco? ❑ No ❑ Yes
Describe briefly your present symptoms:	
On a scale from 1-10 what is your pain level, when it is at its worst? On a scale from 1-10 what is your pain level, when it is at its best?	
What relieves your pain?	
How often do you exercise?	
Have you had any past medical surgeries or procedures? If so (please specify where, when, & for what reason):	
Do you have Arthritis? If so (please specify where):	

CURRENT MEDICATIONS

Drug allergies: ❑ No ❑ Yes

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	**Dose (include strength & number of pills per day)**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

PAST MEDICAL HISTORY

Do you now or have you ever had:

❑ Diabetes (type) _____
❑ High blood pressure
❑ High cholesterol
❑ Thyroid problem
❑ Gout
❑ Cancer (type) _____
❑ Leukemia
❑ Psoriasis
❑ Angina
❑ Heart attack
❑ Chest Pain
❑ Numbness or tingling(where)_____
❑ Parkinson's
❑ Weakness/Fatigue

❑ Heart murmur
❑ Pneumonia
❑ Pulmonary embolism
❑ Asthma
❑ Emphysema
❑ Stroke
❑ Epilepsy (seizures)
❑ Cataracts/ Vision Difficulties
❑ Kidney disease
❑ Kidney stones
❑ Sleeping problems
❑ Frequent Headaches
❑ Migraines

❑ Crohn's disease
❑ Colitis
❑ Anemia
❑ Hearing Difficulties
❑ Hepatitis
❑ Bowel/bladder problems
❑ Incontinence
❑ Tuberculosis
❑ HIV/AIDS
❑ Pacemaker
❑ Bronchitis
❑ Dizziness or Faintness
❑ Vertigo

Other medical conditions (please list):

_____

_____

_____

Are you currently pregnant or breastfeeding? ❑ No ❑ Yes