CORE
PHYSICAL THERAPY

3106 Ponte Morino Dr, Suite A
Cameron Park, CA 95682
Phone: (530) 677-7565
Fax: (530) 677-7683
www.coretherapy..net

Patient Registration Form

Primary Insurance: ☐ Medicare ☐ Group Health Worker's Comp ☐ Lien ☐ Auto ☐ Other ☐ ______________	**Secondary insurance:** Medicare ☐ Group Health ☐ Other ☐ ____________________

☐ New Patient ☐ Returning ☐ New Diagnosis ☐ New Insurance	PTP ☐ Yes ☐ No	PTPN ☐ Yes ☐ No

Patient #	Title	Patient Name (Last, First, Middle Initial)

Address	City/State/Zip

Home Phone ( )	Work Phone ( )	Cell Phone ( )	Email Address

Social Security #	DOB	Gender ☐ M ☐ F	Driver's License #	

Referring Physician		Phone Number ( )	Address

Martial Status: ☐ Married ☐ Single ☐Widowed ☐ Other	Student ☐ Yes ☐ No	Employment Status	Occupation

Employer	Address	City/State/Zip	Phone Number ( )

Emergency Contact	Phone Number ( )	Cell Phone Number ( )	Work Number ( )

Address	City, State Zip	Relationship

Financially Responsible Party Other than Patient

Name (First, Middle Initial, Last)	Relationship to Patient	Email Address

Address	City/State/Zip
Home Phone ( )	Work Phone ( )

Social Security Number	DOB	Gender ☐ Male ☐Female	Driver's License Number

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

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	Address, City, State, and Zip	Phone Number ( )

Is litigation involved? ☐ Yes ☐ No	Name of Attorney	Address, City, State and Zip	Phone number ( )

For office Use Only	
Diagnosis:	**ICD-9 Code:**
Diagnosis:	**ICD-9 Code:**
Diagnosis:	**ICD-9 Code:**

PAYMENT INFORMATION

PAYMENT INFORMATION:
(Check only one box)

I am paying by CASH, CHECK and/or CREDIT and would like a:
- ☐ 30% discount by paying at the time of service
- ☐ Payment plan. I understand fees will apply.

I would like to pay by CASH, CHECK or CREDIT and would like to:
- ☐ Receive a 30% discount by paying the entire bill at the time of service. I'll get reimbursement on my own from my insurance carrier. (Example: Car Accident)

I have INSURANCE and would like to:
- ☐ Have you deal directly with them. I will assign my benefits to you by signing the "Assignment of Benefits" section below.
  - My co-pay for physical therapy is: $__________ per visit
  - My deductible left for this year at start of therapy is: $__________
  - Initial: ______I understand that I must pay any co-insurance or co-pays that are due ***PRIOR*** to being treated for physical therapy.
  - I have given CORE Physical Therapy my insurance cards and have clarified which is my primary and secondary insurance.
  - I understand it is ***MY*** responsibility as the patient to understand my insurance coverage as it pertains to physical therapy. I do not hold CORE Physical Therapy responsible for verifying my benefits or to clarify eligibility for payments by my insurance company.
  - I understand, whether signing as an agent or a patient, that I am individually obligated to pay for my physical therapy treatments to include legal fees and collection expenses should my account become delinquent.

____

Patient Signature (If minor, person financially responsible to sign).

ASSIGNMENT OF BENEFITS: (FOR PATIENTS USING INSURANCE)
- A photocopy of the Assignment shall be considered as effective and valid as the original.
- I authorize release of any medical or other information pertinent to my case to any insurance company, adjuster or attorney involved in this case for the purpose of processing claims and securing payment benefits.
- I authorize the use of this signature on all insurance submissions.
- I authorize CORE Physical Therapy to deposit checks made in my name.
- I authorize CORE Physical Therapy to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- I understand that I am financially responsible for all charges whether or not paid by insurance.

My signature below indicates agreement:

Date: __________ ____

Signature of Insurance Policy holder

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General Health Questionnaire

1. Do you now have or have you in the past had any of the following:

Allergies	Yes	No	Hernia	Yes	No
Balance Problems	Yes	No	High Blood Pressure	Yes	No
Bowel or Bladder Incontinence	Yes	No	HIV/AIDS	Yes	No
Cancer	Yes	No	Kidney Disorders	Yes	No
Circulatory Problems	Yes	No	Osteoporosis	Yes	No
Diabetes	Yes	No	Nervous Disorder	Yes	No
Dizzy Spells	Yes	No	Pregnancy	Yes	No
Headaches	Yes	No	Recent Weight Loss/Gain	Yes	No
Head Injury	Yes	No	Seizures	Yes	No
Heart Disease	Yes	No	Sensitive to heat/ice	Yes	No
Hearing Problems	Yes	No	Stroke/ TIA	Yes	No
Hepatitis C	Yes	No	Vision Problems	Yes	No

If yes on any of the above, please explain and give approximate dates:

___

___

___

2. Have you had treatment for this/these problems before? Yes No

If yes, where and when were you treated:

___

___

3. Have you had surgery related to this/these problems: Yes No

If yes, what type of surgery did you have and when was the surgery?

___

___

___

4. Do you currently have any metal implants: Yes No

5. Do you currently have a pacemaker? Yes No

6. Do you have any communicable diseases? Yes No

If yes, ___________________________

7. List or provide a list of medications you are currently taking

___

___

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Medical History

Name ______________________________
Age________________________________
Date of Birth________________________
Gender □ **Male** □ **Female**

Nature of symptoms

1. Chief Complaint:

____

____

2. Severity of discomfort at present time (circle the appropriate number on the 0 – 10 scale below)
   0 1 2 3 4 5 6 7 8 9 10 (0= No pain 10= Worst pain you have ever experienced)
   a. When did your pain begin? Date: ________________
   b. Was the onset of your pain Sudden Gradual Other ?
   c. Where and how did it begin? (activity and specific cause)

____

____

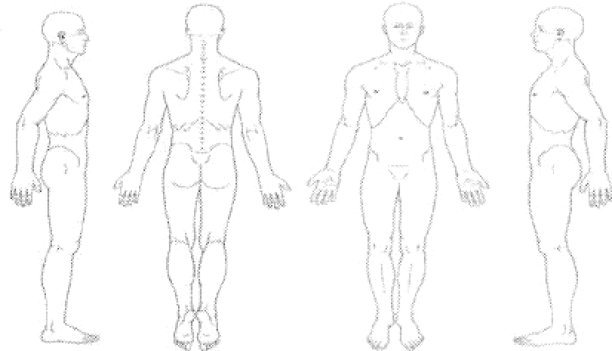
d. Which of the following describes your problem? Worse Better Not changing
e. Just before this onset, were you completely free of discomfort where you have it now? Yes No
f. If not, please list the date and cause of injury and duration and treatment of prior episodes.

____

____

4. Location of symptoms (Please mark the area on the body chart below)

XXXX: Sharp
OOOO: Burning
////: Numbness/Tingling
----: Aching



Behavior of symptoms

1. Which of the following describes your discomfort? Constant Intermittent
   a. If intermittent, how often does it recur?

   ____

   b. When it recurs, how long does it last?

   ____

   c. How long can you be free of discomfort?

   ____

2. Describe your discomfort over a typical day.
   Worse in the morning Worse as the day goes on Worse in the evening No pattern
3. What activities or positions aggravate your condition?

____

4. What activities or positions relieve your condition?

____

5. What functional activities are limited by you condition?

____

Other information

1. What are your goals?

____

Important Company Policies for a Successful Relationship

We strive to provide you the best personalized care available. To make this possible we adhere to a set of very important guidelines. Please read them carefully, initial all the boxes, and indicate your agreement by signing at the bottom.

Initial All Boxes

☐ **Late Policy "10-minutes"**
Being late by more than 10 minutes will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. We do not allow appointment overlap because this undeservedly compromises the care of another patient.

☐ **24-Hour Advance Notice Fee**
If you wish to change or cancel an appointment we require a minimum ***24-hour advance notice***. Anything less will result in a ***$10 fee*** charged to your account. It costs us money to make appointments available to you. Whether you attend or not we still accrue the expenses (for staff wages, rent, etc.). We don't charge you the actual cost for that appointment but rather a mere ***$10 fee***. We do NOT make money with this charge; it's only to act as a deterrent from making last minute changes. Advance notice allows someone else (who needs it) time to reserve it in place of you. Please be courteous and responsible. Thank you.

☐ **Copays are due upon arrival**
If you happen to forget your wallet or checkbook we may still be able to see you upon completion of an "Extension Request" form. This is a "promise-to-pay" form and carries a minimal fee that allows you to keep your appointment.

☐ **No-shows are bad**
If you fail to show for an appointment without notice all future appointments will be removed and a ***$10 fee*** assessed to your account. You may re-schedule appointments again on a "first come, first serve basis".

☐ **Cell phones must be shut OFF or silent.**
We realize emergencies may arise and therefore allow you to carry your cell phone during your session, however, please be courteous and set to silent mode or turn off. Thank you.

☐ **Children requiring supervision are NOT allowed to attend sessions with you.**
Unless your facility offers child care services, you may not bring children who require supervision with you to your appointment. If your child does not require supervision and is capable of waiting for you quietly then you may bring them. If any disturbance is caused to other patients or staff members you may be asked to terminate your session early and attend to your child.

☐ **Financial Hardship**
If you are experiencing financial difficulties and are unable to afford the cost of our services we have a "Financial Hardship Form" which may be filled-out. If you quality for financial assistance according to the Federal guidelines, we may legally assist you by waiving or discounting your (patient responsibility) portions of the bill. Ask the front desk person for assistance.

☐ **Important Notice from the Federal Government:**
"It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments . . . even if your doctor allows it. Unless you complete a "Financial Hardship" form and qualify for financial assistance under Federal Standards, you may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan even if your doctor allows it. You both may be charged for breaking the law. This includes services deemed as "professional courtesy" and "TWIP's - Take what insurance pays". Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, State Insurance Fraud Laws. Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128 A(a)(5) of the Health Insurance Portability and Accountability Act of 1996 [section 231(h) of HIPAA]. Exceptional cases do apply. Please see contact info for more information. Office of Inspector General, Department of Health and Human Services. Contact by by phone: 202 619-1343, by fax: 202 260-8512, by email: paffairs@oig.hhs.gov, by mail: Office of Inspector General, Office of Public Affairs, Department of Health and Human Services, Room 5541 Cohen Building, 333 Independence Avenue, S.W., Washington, D.C. 20201, Joel Schaer, Office of Counsel to the Inspector General, 202 619-0089."

We look forward to building a successful relationship with you that lasts a lifetime!

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

USES AND DISCLOSER OF YOUR MEDICAL INFORMATION

For Treatment: We may use medical information about you to provide you with medical treatment or services. **For Payment:** We may use and disclose 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 third party. **For Health Care Operations:** We may use and disclose health information 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 health-related services or recommend possible treatment options or alternatives that may be of interest to you. **As Required By Law:** We will disclose 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 workers' 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 Directors:** 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, counterintelligence, and other national security activities authorized by law. **For Protective Services for the President and Others:** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized 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 a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

YOUR RIGHT TO INSPECT AND COPY: To inspect and copy of your 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 any disclosures of your medical information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously 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 you for treatment, payment, or health care operations. **We are not required to agree to your request. Your Right to Request Confidential Communications:** 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 right to change this notice, and will post the current notice in our facility.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the practice 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 revoke 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.

By my signature below I acknowledge receipt of a copy of the Notice of Privacy Practices.

____ ______________

Patient or Personal Representative Signature **Date**