Family
PHYSICAL THERAPY
BRETT PINKNEY, M.P.T. & ASSOCIATES, INC.

Patient Registration Form

Please fill out the forms and return to the front desk.

Patient Name:_____ Gender: Male ☐ Female ☐ Other ☐

Date of Birth:_____ Age:_____ SSN: _____

Address:_____ City:_____ State:____ Zip:_____

Home Phone #:_____ Cell Phone #:_____

Email Address:_____

Work Status: Full Time ☐ Part Time ☐ Unemployed ☐

If Under 18: Parent/Guardian:_____ Relationship to Patient:_____

Emergency Contact Name: _____

Relationship: _____ Phone #: _____

Do you smoke? Yes ☐ No ☐ Are you on blood thinners? Yes ☐ No ☐

Current Medications?_____

_____

Insurance Information

Primary Insurance

Insurance Name:_____

Policy #: _____

Group # (if applicable):_____

Secondary Insurance

Insurance Name: _____

Policy #: _____

Group # (if applicable):_____

Patient/Guardian Signature: _____ Date: _____

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Patient Information & Consent Form

Please initial and sign on all required lines

CONSENT FOR CARE AND TREATMENT: I hereby agree and give my consent to Family Physical Therapy to provide the necessary rehabilitative care and treatment, as considered necessary and in the best interest in order to address the physical condition. I understand that the benefits and risks to all interventions will be explained and that the patient holds the final judgment in such matters. **INITIALS: _____**

NOTICE OF PRIVACY PRACTICES (HIPAA Acknowledgment/Consent): I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Family Physical Therapy, its subsidiaries, and/or affiliates. In addition, I hereby consent to the use and disclosure of my personal health Information for the purposes of treatment, payment, and healthcare operations. **INITIALS: _____**

AUTHORIZATION TO RELEASE PATIENT INFORMATION: I hereby authorize Family Physical Therapy to release any protected health information required in the course of my evaluation or treatment to the insurance company, or their affiliates, to which I provided the information. I also authorize the release of appointment information left in a voicemail, email, or text message and understand the level of privacy risk associated with these forms of communication. **INITIALS: _____**

HIPAA CONSENTS: In compliance with HIPAA regulations, I consent to the following individuals receiving verbal information regarding appointment information and/or the billing of my account:

Name/Relationship **Name/Relationship** **Name/Relationship**

AUTHORIZATION TO PAY: I hereby authorize insurance payment directly to Family Physical Therapy, 2231 Douglas Blvd Suite 100, Roseville CA 95661, for medical services rendered. I understand that the Benefit Verification is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage and that I am financially responsible for the charges not covered by my insurance. In the event of default, I promise to pay collection costs and reasonable fees as may be required to obtain collection of this account. **INITIALS: _____**

ATTENDANCE AGREEMENT: At Family Physical Therapy, we understand that scheduling conflicts occur, and we will make every effort to accommodate you. However, we do ask for common courtesy in return and that you cancel no later than 24 hours before your appointment. If you do not call to cancel an appointment or cancel the same day, that will be considered a No-Show and you will be subject to a $50 No-Show fee that must be paid before or at your next appointment. If you have 2 No-Shows, you will be discharged as a patient, and your referral will be sent back to your referring physician/provider. **INITIALS: _____**

AUTHORIZATION TO COMMUNICATE ELECTRONICALLY: I understand authorized personnel (including my physical therapist) from Family Physical Therapy may communicate with me regarding scheduling/ appointments, the treatment provided, home exercise programs, and educational or informative content as it relates to my condition. I understand that my protected health information will not be communicated electronically. I understand that I have the opportunity to opt out of all future electronic communications at any time by contacting front office staff and updating preferences. **INITIALS: _____**

My signature below certifies I have read, understand, and fully agree to each statement in the document.

Printed Name: _____ Date: _____

Patient/Guardian Signature: _____ Date: _____

Patient Medical History Form

Reason for Visit: _____

Date of Injury: _____ Surgery Date (if applicable): _____

Prior Treatment: _____

Pain rating in the last 24 hours from 0-10: _____ Height: _____ Weight: _____

List any recent diagnostics (Xray, MRI, CT, injections, etc.): _____

Do you have any allergies (Latex, cold, heat, medications, etc.)? Yes ☐ No ☐

Have you fallen in the last year? Yes ☐ No ☐

Past Medical History

Check yes or no for each of the following conditions

Condition	Yes	No	Condition	Yes	No
Heart Disease			Head Injuries		
Pacemaker			Concussion		
High Blood Pressure			Metal or Surgical Implants		
Stroke			Thyroid Problems		
Seizures/Epilepsy			Hypersensitivity to Cold/Heat		
Vascular Disease			Cancer		
Deep Vein Thrombosis (DVT)			Tumors		
Asthma			Recent Weight Gain/Loss		
Respiratory Disease			Hernia		
Chronic Cough			Hepatitis		
Shortness of Breath			Kidney/Bladder Problems		
Tuberculosis			Substance Abuse		
Current/Recent Infections			Depression		
Diabetes			Anxiety		
Hypoglycemia			Hearing Loss		
Fainting Spells			Learning Disabilities		
Anemia			Arthritis		
Headaches/Migraines			Osteoporosis		