Camas Physical Therapy

REGISTRATION FORM

(Please Print)

Today's Date:	**Email Address for our Newsletter:**			
PATIENT INFORMATION				
Patient's Last Name: **First:** **Middle:**			☐ Mr. ☐ Miss. ☐ Mrs. ☐ Ms.	
Is this your legal name? ☐ Yes ☐ No	**If not, what is your legal name?**	**Birth Date:** / /	**Age:**	**Sex:** ☐ M ☐ F
Street Address / P.O. Box	**S.S.N:**	**Home Phone:** ( )		
City/State/Zip:		**Cell Phone:** ( )		
Occupation:	**Employer:**	**Employer Phone Number:** ( )		
Chose Clinic Because/Referred to Clinic by (please check one box): ☐ **Dr.** ☐ **Hospital** ☐ **Insurance Plan**				
☐ **Family** ☐ **Friend** ☐ **Close to Home/Work** ☐ **Yellow Pages** ☐ **Internet**				
☐ **Motor Vehicle Accident** ☐ **Workmen's Comp** ☐ **No Insurance**				

INSURANCE INFORMATION			
(Please give your insurance card to the receptionist)			
Insurance Company:	**Address:**	**Insurance Phone:** ( )	
Policy Number:	**Group Number:**		
Employer:	**Employer Phone Number:** ( )		
Are you covered by more than one insurance company? ☐ **Yes** ☐ **No**			
Please indicate primary insurance: ☐ **MVA** ☐ **Work Comp** ☐ **Medicare** ☐ **Cash**			
Name of Secondary Insurance (if applicable):	**Subscriber's Name:**	**Group No.:**	**Policy No.:**
Patient's Relationship to Subscriber: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**			
Guardian Name (please print):			

IN CASE OF EMERGENCY			
Name of Local Friend of Relative:	**Relationship to Patient**	**Phone No.:** ( )	**2nd Phone No.:** ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Camas Physical Therapy or insurance company to release any information required to process my claims. If balance becomes delinquent, I agree to pay all collection costs. Accounts over 60 days may be subject to a monthly finance charge of 12% per year of the unpaid balance UNLESS financial arrangements have been made prior. A $50 bank fee will be charged for NSF checks.

** If the patient is a minor, a parent or guardian must sign below to consent to treatment and agree to financial responsibility for the care**

Patient/Guardian Signature: ***Date:***

Camas PHYSICAL THERAPY
3252 NE 3rd Ave. Suite #2
Camas, WA 98607
Phone: 360-835-7427 Fax: 360-835-0653

Thank you for selecting Camas to be a part of your rehabilitation. Below we have condensed most of our policies as to be efficient with your valuable time. Please review:

Intake Form: This is to aid in the initial evaluation process. It is a small glance into your medical health and this particular episode of pain.

Registration Form: This form allows for personal/contact information and insurance information to assist with verification of benefits.

Financial Agreement: This explains in detail the professional relationship between the patient and Camas Physical Therapy.

HIPAA: This form will explain your rights as a patient and to your privacy.

1) **Release of Records:** I authorize Camas Physical Therapy to request a copy of my medical records and/or billing statements for the purpose of assisting in my rehabilitation. I also authorize Camas Physical Therapy to release or discuss all medical information with my healthcare providers, case managers, lawyers, or other involved in my care.

2) **Cancellation Policy:** Due to the nature of our business having an updated schedule is of utmost importance, we appreciate your cooperation.

   A $35.00 cancellation fee for the FIRST appointment not cancelled within 24 hours of scheduled appointment.

   NO SHOW of appointment times or the SECOND appointment not cancelled within 24 hours of the scheduled appointment will be assessed with a $50.00 fee.

   I agree to above stated release of records, cancellation policy, and certify that I have either printed above mentioned forms online or been given forms at clinic.

Patient Signature **Date**

Parent/Guardian Signature (if patient is under 18 years of age – signature required) Date

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Notice of Patient Information Practices

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

Camas Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURE OF HEALTH INFORMATION

Camas Physical Therapy uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care provided. For example, we may use your personal information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you. Camas may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any situation, Camas's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop disclosures at any time.

We may change our policy at any time. When changes are made, a new Notice of Information Practices will be posted in a common area of our clinic. You may also request an updated copy of our Notice of Information Practices at any time.

Patient's Individual Rights

You have the right to review or obtain a copy of your personal heath information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. Camas Physical Therapy will consider all such requests on a case-by-case basis, but the company is not legally required to accept them.

Patient Signature **Date**

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Financial Policy

Thank you for choosing Camas Physical Therapy for your physical therapy needs. We will work closely with you and your physician to provide you with a successful plan of care. Please understand that timely payment for your treatment is an important role in the process. Your clear understanding of our financial policy is vital to our professional relationship.

Our policy states:

- All co-pays, co-insurances and deductibles are due at the time of service.
- Payment is due in full at time of services unless arrangements have been made.
- If you are unable to make full payments at the time of service, please ask to speak with our Office Manager.
- We accept cash, checks or credit/debit cards.
- If any portion of your account balance exceeds 60 days, you will be held responsible for this amount.
- Accounts over 60 days are subject to a finance charge of 12%.

Insurance

Camas accepts Medicare, all major insurance companies and numerous PPO and managed care contracts. Please be aware that some and perhaps all, of the services provided may be considered not medically necessary by your insurance provider. You will be held responsible for these charges.

Your medical insurance is a contract between you and your insurance company. We are not a party to this contract. Camas Physical Therapy will submit all claims and charges to your insurance provider as a service to you. Co-pays must be paid at the time of service in order to abide by your insurance contract. If your policy requires a referral, failure to present this prior to services rendered may result in a loss of benefits. If you need assistance in obtaining this referral, please contact our front office. If payment arrangements have not been made or full payment is not received in 60 days from the date of service, your account may be turned over to a collection agency and you will be held responsible for all fees incurred.

Please be advised there will be a $50 fee for NSF checks.

Thank you for understanding our financial policies. If you have any concerns, please discuss them with our Office Manager or Billing Specialist.

Patient Signature **Date**

Parent/Guardian Signature (if patient is under 18 years of age – signature required) Date

MEDICAL RELEASE OF INFORMATION

I, _____, authorize the office of Camas Physical Therapy to release information concerning my insurance information, medical history, diagnosis, treatment, prognosis and recommendations, as well as other pertinent data regarding my insurance, healthcare or upcoming appointments to:

(Check all that apply)

_____ Spouse (name) _____

_____ Any other family member (names) _____

_____

_____ Home phone answering machine/service

_____ Cell phone answering machine/service

_____ Work phone

_____ Message phone (specify) _____

_____ Other (specify) _____

_____

Signature of Patient Date

_____

Witness Date

Date: _____ Name: _____

Occupation: _____ Height: _____ Weight: _____

Referring Physician:_____ Age:_____

Date of Injury: _____ Date of Surgery: _____ Diagnosis:_____

What major complaint/symptom/issue brings you here today?

_____

How did it start?

_____

How long has it been happening?

_____

Are your symptoms getting: ☐ Better ☐ Worse ☐ Staying the same

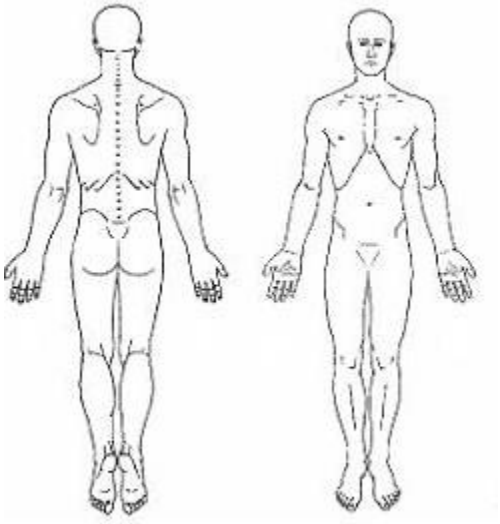
Are your symptoms: ☐ Constant ☐ Intermittent

Place three circles below to indicate the intensity of your pain on **average**, at **best**, and at **worst.**

0 1 2 3 4 5 6 7 8 9 10

No Pain….. ….Worst Pain Imaginable

Please indicate the location of your symptoms on this diagram:



Please check the box of the activity that increases your pain or symptoms:

☐Walking	☐Household/Yard work	☐Sleeping/resting	☐Other:_____
☐Standing	☐Sports	☐Playing with kids	_____
☐Sitting	☐Bathing/dressing	☐Climbing stairs	
☐Sit to Stand	☐Driving/riding in a car	☐Computer work	
☐Reaching	☐Exercise	☐Lifting/carrying	

What decreases your pain/symptoms?:_____

_____

What are your goals for Physical Therapy:

_____

Have you seen any of the following during the past 3 months?
☐Physician ☐Chiropractor ☐Acupuncturist ☐Massage Therapist ☐Physical Therapist

Past Medical History – Please check the box if you have or have ever had any of the following:

☐Anxiety	☐High Blood Pressure	☐Stroke	☐Fractures
☐Depression	☐Pacemaker	☐Thyroid problems	☐Sprains/strains
☐Diabetes	☐Heart problems	☐Osteoarthritis	☐Fibromyalgia
☐Lung problems	☐Dizziness/Vertigo	☐Rheumatoid arthritis	
☐Liver problems	☐Recent falls	☐Headaches	☐Vison problems
☐Cancer	☐Heart attack	☐Motor Vehicle Injury	
☐Osteoporosis	☐Recent weight loss/gain	☐Balance problems	☐Hearing problems

Use the following lines to explain/describe any of the above checked conditions if needed:

_____

_____

_____

Have you had any past surgeries or hospitalizations? ☐ Yes ☐No (please list them if yes)

_____

_____

Have you had any of the following tests performed for this problem?
☐X-Ray ☐MRI ☐CT Scan ☐Bone Scan ☐Blood Test ☐Other:_____
Results:_____

Allergies:
☐Medications ☐Latex ☐Adhesive Tapes ☐Other
List:_____

Medications: Please list all prescription and non-prescription medications (especially heart related):

_____

_____

_____