PATIENT REGISTRATION

PLEASE PRINT

A. PATIENT INFORMATION

Last Name _____

First _____ M.I. _____

Address _____

City _____

State _____ Zip _____

Home Phone _____ Work Phone _____

Primary Physician _____

Date of Birth _____

Place of Birth: State: _____

Country: _____

Sex: M ____ F ____ SS# _____

Status: ☐ Single ☐ Married Other _____

Race: ☐ Caucasian ☐ African-American

☐ Asian/Pacific Islander ☐ Hispanic White

☐ Hispanic Black ☐ Nat. American/Eskimo/Aleut

Other _____

Religious Preference _____

B. EMERGENCY CONTACT

Last Name _____ M.I. _____

First _____ DOB _____

Address _____

City _____ State _____ Zip _____

Phone _____ Relationship _____

C. PATIENT EMPLOYMENT

Employed: ☐ Full-time ☐ Part-time

☐ Self-employed ☐ Disabled _____ (date)

☐ Retired Date of Retirement _____

Occupation _____

Employer _____

Address _____

_____

Phone _____ Fax _____

D. INJURY INFORMATION

Chief Complaint _____

Date of Injury/Onset _____

If Accident:

Date of accident _____ Time of accident _____ AM/PM

Place of accident _____

Nature of accident/type _____

E. ADVANCE DIRECTIVE / LIVING WILL

Do you have one? _____

If not, would you like information? _____

F. INSURANCE INFORMATION

Insurance Co. _____

Address _____

_____

Group# _____ ID# _____

Effective Date _____

Phone _____

If Workers' Comp:

Claim # _____

Adjustor _____

Phone _____

Medicare # _____

Effective Date: Part A _____ Part B _____

Policyholder is: ☐ Self ☐ Spouse ☐ Parent

If policyholder is not self, complete section G below.

G. POLICYHOLDER (if NOT patient)

Complete this section only if patient is NOT the policyholder.

Policyholder name _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ SS# _____

Sex: M ____ F ____

Employer _____

Address _____

_____

Phone _____

Occupation _____

☐ Full-time ☐ Part-time ☐ Self-Employed

H. SECONDARY INSURANCE

If you have secondary insurance, please complete.

Secondary Insurance Co. _____

Address _____

_____

Group # _____ ID # _____

Effective Date _____

Phone _____

Medicare # _____

Effective Date: Part A _____ Part B _____

Policyholder is: ☐ Self ☐ Spouse ☐ Parent

Employer (if patient is NOT policyholder) _____

Address _____

Phone _____

Occupation _____

☐ Full-time ☐ Part-time ☐ Self-Employed

FOR STAFF ONLY: NPP ☐ Yes ☐ No

Mindful Physical Therapy

901 Sir Francis Drake Blvd., Suite B
Kentfield, CA 94904
(415) 256-9990 phone (415) 256-9991 fax

Notice of Privacy Practice

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information.

USES AND DISCLOSURES 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 to 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 of 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 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 of accounting for any disclosures of your medical information we have made, except for uses and disclosures of 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_____

Mindful Physical Therapy

901 Sir Francis Drake Blvd., Suite B
Kentfield, CA 94904
(415) 256-9990 phone (415) 256-9991 fax

Consent to Physical Therapy, Billing Policy, Release, and Authorization

Please read and initial on lines.

_____I have read and understand the Notice of Privacy Practice.

_____I have reviewed the Intake Form and all the information is true and accurate to the best of my ability.

_____I voluntarily authorize Mindful Physical Therapy to perform outpatient evaluations and physical therapy treatments as necessary. I understand that the practice of physical therapy is not an exact science, and therefore acknowledge that no guarantee can be made as to the result of any treatment or care administered. While the plan of care is to improve function with less or no pain, I understand the potential risk for increased symptoms.

_____I recognize that the practice of physical therapy may involve the touching of my body by the therapist and that partial disrobing may be required to facilitate such care, all of which is expressly consented to by me.

_____I authorize Mindful Physical Therapy to bill my insurance company directly for the covered portion of the charges, and I authorize payment of medical benefits directly to Mindful Physical Therapy. I authorize Mindful Physical therapy to release medical or other information necessary to process this claim. I understand that I am ultimately responsible for my physical therapy charges, and I agree to pay my deductible, co-insurance or co-payments, and any charges not reimbursed by my insurance carrier.

_____I understand that some insurance companies require medical or administrative pre-authorization for treatment, or have reimbursement limits on physical therapy treatment. I understand that I am responsible for knowing and meeting the requirements of my insurance plan.

_____I understand Mindful Physical Therapy requires a minimum 24-hour advance notice for cancelations. Failure to show for a scheduled appointment without notice or failure to provide 24-hour advance notice for cancelations will result in a $45.00 fee, which is not covered by insurance.

Patient, Parent or Legal Guardian (Print) _____

Patient, Parent or Legal Guardian (Signature) _____

Date _____