Energy Physical Therapy

16573 Ventura Blvd. # 5
Encino, CA 91436
Tel: (818) 990-0868 Fax: (818) 990-2868

REGISTRATION FORM

Last Name: _____First:_____Date of birth:_____Age:____

Address:_____City:_____Zip Code:_____

Home Phone:_____Cell Phone:_____

Driver License:_____ Marital Status:_____ Gender: M F

Employer:_____ Occupation:_____

Referred By:_____Referring Physician_____

Email Address:_____

Emergency Contact Name: Last _____First:_____Relationship:_____

Home Phone:_____ Cell Phone:_____

Assignment of Insurance Benefits

I hereby authorize direct payment of physical therapy/rehabilitation medicine benefits to Energy Physical Therapy, Inc.

I understand that I am financially responsible for any balance not covered by my insurance.

Patient's authorization of treatment:

I hereby give my consent for treatment of above condition or injury in accordance with ethical practice of physical therapy including modalities, exercises, and procedures as evaluated by the physical therapist and/or prescribed by my medical doctor. I hereby understand that I will be an active participant in determining the goals and treatment and have the right to express all concerns related to my well-being.

Patient's Signature: _____**Date:**_____

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PATIENT HISTORY

Please complete this form completely. This will assist us in properly treating you and identifying possible contraindications for certain treatments. All information is held in strict confidence.

Patient Name:_____Date: _____

Date of Last physical examination:_____

Date of Injury or Onset of Complaint(s):_____

Work related: ☐ Auto Accident related: ☐

History of loss of balance or falls _____

Height: _____ Weight: _____

Briefly describe how you were injured or how complaints began (i.e. after gardening, lifting…….):

_____

_____

Where is your pain/injury located?_____

Check (X) symptoms you currently have or have had in the past year.

Pain, weakness, numbness in: ☐ Hands ☐ Wrist ☐ Elbow ☐ Neck ☐ Shoulders

☐ Thoracic ☐ Hips ☐ Low Back ☐ Knee ☐ Legs ☐ Feet

If you have any metal or other implants in your body, please describe where they are:_____

_____

_____

Have you had physical therapy before for this condition? ☐ Yes ☐ No

If yes, what year and how many visits?_____

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Conditions/Symptoms **Check (X) symptoms you currently have or have had in the past year.**

☐	AIDS	☐	Alcoholism	☐	Anemia	☐	Arthritis
☐	Asthma	☐	Cancer	☐	Diabetes	☐	Gout
☐	Bleeding Disorders	☐	Heart Disease	☐	High Cholesterol	☐	HIV Positive
☐	Hepatitis	☐	Hernia	☐	Kidney Disease	☐	Mononucleosis
☐	Liver Disease	☐	Multiple Sclerosis	☐	Pacemaker	☐	Psychiatric care
☐	Stroke	☐	Suicide Attempt	☐	Thyroid Problems	☐	Tuberculosis
☐	Venereal Disease	☐	History of Seizures	☐	Depression	☐	Loss of hearing
☐	Chest pain	☐	Dizziness	☐	Lack of bladder control	☐	High blood pressure

Medications **List medications you are currently taking.**

Allergies

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Hospitalizations

Year	Reason for Hospitalization & Outcome

Serious Illness / Injuries

	Date	Outcome

I certify the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Name

Signature

Date

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CONSENT TO RELEASE MEDICAL RECORDS

I_____consent to have my medical records released to the health professionals at ENERGY PHYSICAL THERAPY, INC. I understand that these records will be used to help understand the extent of my rehabilitation process and will be kept in strict confidentiality.

_____ _____
Signature of patient Date

_____ _____
Signature of Requesting Professional Date

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Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which we require you read and sign prior to any treatment.

Full payment is due at the time of service.
We accept cash, check

Regarding insurance:

In order for us to bill your insurance company, we require that you provide us with your insurance information. Your insurance policy is a contract between you and the insurance company. We are not part of that contract. If we do accept assignment of benefits from your insurance company, we require that you pay any and all unpaid balances. We can offer you a pre-approved payment plan, or you may provide us with a credit card with authorization to bill that account for the balance.

If your insurance company has not paid your account in full in 60 days, the balance will automatically become yours. Please be advised that some, and perhaps all, of the services provided may not be covered services, and not considered reasonable and customary under the Medicare program and or other medical insurance. If you have any questions regarding reasonable and customary charges for your insurance policy, please contact them directly.

If treatment received is for a Personal Injury where a third-party insurance or attorney is involved, I am granting Energy Physical Therapy a lien against and a security interest in any claim that may have arisen from my accident/injuries, and ordering my attorney to pay to you all sums (including interest) which may then be due to you prior to disbursing any funds. I further expressly waive and release any claim of exemption I may otherwise have under federal or state law with respect to the referenced proceeds. In the event legal action should become necessary to collect an unpaid balance due for services rendered to me, I/we agree to pay reasonable attorney's fees and/or other such costs as the Court determines proper.

Missed appointments:

Unless cancelled at least 24 hours in advance, our policy is to charge a **$30 fee** for a missed appointment. Based on your request for scheduling, we make our staff available for your needs. Please help us to serve you better by keeping scheduled appointments.

I understand and agree with the above Financial Policy.

_____ _____

Patient's Signature Date

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Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operation, is made pursuant to the requirements of 45 CFR § 164.520(c) (2) (ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following Information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Energy Physical Therapy (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.

2. I am aware that the Practice maintains a Privacy Notice that sets forth the types of uses and disclosures that the Practice permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.

3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address:
16573 Ventura Blvd. # 5, Encino, CA 91436 Attention: Practice Compliance Director.

4. I understand and acknowledge that I have the right to request that the practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operation. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing. I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions):

_____

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

_____ _____
Signature of Patient or Representative Date

_____
Patient's Name

_____
Name of Personal Representative (if applicable) Relationship to Patient

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Physical Therapist-Patient Arbitration Agreement

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physical therapist including any spouse or heirs of the patient and any children, whether born or unborn at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term " patient" herein shall mean both the mother and the mother's expect child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small court against the physical therapist and the physical therapist's partners, associates, association, corporation or partnership, and the employees, agents, and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, or punitive damages. Filing of any action in any court by the physical therapist to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrator's appointment by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration-incurred pr approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issue of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joined in this arbitration of any person or entity, which would otherwise be a proper additional party in a court action, and upon such intervention and joined any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes with this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the

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date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitation, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the California Code of Civil Procedure provisions relating to arbitration shall govern the arbitrators.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physical therapist within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as the date of first medical services

_____
Patient's or Patient's Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Patient or Patient's Representative's Signature Date

_____ _____
(If Representative, Print Name and Relationship to Patient) Date

By: _____ _____
Authorized Representatives Date