Patient Registration

Date MM/DD/YYYY _____

Name _____
First *Middle* *Last*

Address _____
Street

_____
City *State* *Zip Code*

Phone (mobile) _____ DOB MM/DD/YYYY _____

Phone (home) _____ Email _____

Phone (work) _____

Gender ☐ Female ☐ Male Marital Status ☐ M ☐ S ☐ W

How did you hear about us? ☐ Physician ☐ Former patient ☐ Online search ☐ Other

Please specify: _____

Have you previously been treated at Propel Physical Therapy of Woodland Hills? ☐ Yes ☐ No

EMERGENCY CONTACT INFORMATION

Name _____ Relation _____
First *Last*

Home/Work Phone _____ Mobile _____

EMPLOYMENT INFORMATION

Employer/School _____ Occupation _____

ADDITIONAL INFORMATION

Referring Physician _____ Phone _____

Patient Registration

FINANCIAL POLICY

- Patients with health or other insurance should remember that services are charged to you, the patient, not your insurance company.
- As a courtesy to our patients, we verify your insurance coverage and benefits (**verification is only an estimate*) as well as file therapy claims for you. However, we do not accept responsibility for settling claims with your carrier.
- If payment is delayed, reduced or denied by your insurance carrier, you are responsible for settling your balance with us.
- The estimated patient responsibility amount is due at time of service.

Assignment of Benefits: I hereby authorize any insurance benefits for my treatment that are otherwise payable to me to be paid directly to O'Real Cotton, Doctor of Physical Therapy, Inc./DBA Propel Physical Therapy of Woodland Hills.

_____

Patient/Guarantor Date MM/DD/YYYY

_____

If guarantor, please print name

PAYMENT AUTHORIZATION

I hereby authorize Propel Physical Therapy of Woodland Hills to charge my credit card in the event my account becomes overdue or if my check is returned by the bank.

Type of Credit Card ☐ Visa ☐ Mastercard Exp Date _____

Credit Card Number _____ V-Code_____

Name as it appears on card _____

Signature _____ Date MM/DD/YYYY _____

Patient Registration

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge my review of Propel Physical Therapy of Woodland Hills' Notice of Privacy Practices. Propel Physical Therapy of Woodland Hills will use or disclose my PHI for the purposes of carrying out **Treatment, Payment and Health Care Operations**. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand Propel Physical Therapy of Woodland Hills has reserved a right to change its privacy practices that are described in the Notice. I also understand a copy of any Revised Notice will be provided to me or made available at my next office visit.

I give my consent for Propel Physical Therapy of Woodland Hills to notify me of new facilities or services. I understand that I may revoke this consent at any time by giving written notice of my desire to do so to Propel Physical Therapy of Woodland Hills.

Signature _____ Date MM/DD/YYYY

If you are not the patient, please specify your relationship to the patient

RECEIPT OF CA PHYSICAL THERAPY BOARD NOTICE

I hereby acknowledge my review of the California Physical Therapy Board's notice (form NTC 12-01). The notice provides information about verifying a license, what to expect when receiving care, patient rights, and how to file a complaint.

Signature _____ Date MM/DD/YYYY _____

If you are not the patient, please specify your relationship to the patient

Appointment Policy

WHEN ABLE, PLEASE SCHEDULE YOUR APPOINTMENTS AT LEAST ONE WEEK IN ADVANCE TO ENSURE THE TIMES YOU NEED. Appointment times reserved one week do not automatically follow through to subsequent weeks.

KINDLY GIVE AT LEAST 24 HOURS NOTICE FOR CANCELLATION OR RESCHEDULING. Please give 24 hours notice if you are unable to attend your appointment or you will be charged a late cancellation fee of $50. Please attend your appointment as scheduled; our customary fee of $75 will be charged for not showing up to a pre-scheduled appointment. Since insurance companies and workers compensation do not pay for broken appointments, these charges will be solely your responsibility.

PLEASE BE TIMELY FOR APPOINTMENTS. If you arrive more than 15 minutes late for your scheduled appointment, your appointment may have to be rescheduled.

_____ _____

Patient/Guardian Signature Date MM/DD/YYYY

Informed Consent for Physical Therapy

Physical therapy involves the use of many different types of physical evaluation and treatment. At Propel Physical Therapy of Woodland Hills, we use a variety of procedures and modalities as we attempt to improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy.

Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition for which you are seeking treatment. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions.

You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time before or during your treatment session.

Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them.

I acknowledge my treatment program has been explained by Propel Physical Therapy of Woodland Hills, and all of my questions have been answered to my satisfaction. I understand the risks associated with a program of physical therapy as outlined to me, and I wish to proceed.

_____ _____

Patient/Guardian Signature Date MM/DD/YYYY

_____

Patient/Guardian Name

Informed Consent for Physical Therapy Telehealth

Physical therapy involves the use of many different types of evaluation and treatment, including telehealth. As with all forms of medical treatment, there are benefits and risks involved with telehealth physical therapy. Given the unique nature of receiving physical therapy services via telehealth, there are some special considerations to understand before participating.

1. Patient consents to being photographed, recorded, or videotaped and to the storage of this data, if applicable. If recorded, data may be stored for up to 7 years.
2. There is a possibility of failure of the technologies used to provide telehealth services and patient will hold provider harmless for medical or other information lost because of technology failures.
3. The laws that protect privacy and the confidentiality of medical information also apply to telehealth, and no identifying information obtained in the use of telehealth will be disclosed to researchers or other entities without patient's written consent.
4. Patient has the right to withhold or withdraw consent to the use of telehealth at any time.
5. Telehealth may involve electronic communication of patient's personal medical information to other medical practitioners.
6. Patient may expect the anticipated benefits from the use of telehealth, but results cannot be guaranteed or assured.
7. Healthcare information may be shared with other individuals for regular business purposes, including scheduling and billing. Entities will maintain the privacy and confidentiality of the information obtained.

I understand the risks associated with a telehealth physical therapy program as outlined to me, and I wish to proceed.

_____ _____

Patient/Guardian Signature Date MM/DD/YYYY

_____

Patient/Guardian Name

Medical History

Please answer all questions to the best of your ability.

1. Patient Name _____

2. Age _____ 3. Height _____ 4. Weight (lbs) _____

5. What problem are you being treated for today? _____

6. When did your problem begin? _____

7. What kind of testing have you received for this problem?

   Please check: ☐ X-Ray ☐ MRI ☐ CT Scan ☐ Bone Scan ☐ Other

   Please explain results:

8. Have you received treatment for these symptoms? ☐ Yes ☐ No

   If yes, what type? _____

9. Have you received physical/occupational therapy within the last calendar year? ☐ Yes ☐ No

   If yes, was it for your current problem? ☐ Yes ☐ No

   Approximately how many treatment sessions have you received this calendar year? _____

10. Have you received home health care at any time within the last six months? ☐ Yes ☐ No

11. Are you currently working? ☐ No ☐ Yes ☐ Light duty ☐ Full duty

12. What is your occupation? _____

13. Does your occupation require: ☐ Sitting ☐ Standing ☐ Walking ☐ Lifting

14. Are you currently taking any medications? ☐ Yes ☐ No

    If yes, please list medications and dosage:

15. Do you have any known drug allergies? ☐ Yes ☐ No

16. Have you had any surgeries or significant past medical history? ☐ Yes ☐ No

    If yes, please list:

Medical History

17. Please CHECK any conditions you have currently or have experienced in the past.

- ☐ Bone or joint disease
- ☐ Tendonitis/bursitis
- ☐ Broken/fractured bones
- ☐ Arthritis
- ☐ Spasms/cramps
- ☐ Sprains/strains
- ☐ Low back, hip, leg pain
- ☐ Neck, shoulder, arm pain
- ☐ Headaches/head injuries
- ☐ Jaw pain/TMJ
- ☐ Lupus
- ☐ AIDS/HIV
- ☐ Diabetes
- ☐ Seizures
- ☐ Cancer/tumors
- ☐ Heart condition
- ☐ Thyroid problems
- ☐ Lymphedema
- ☐ Kidney problems
- ☐ Irritable Bowel Syndrome
- ☐ Herpes/shingles
- ☐ Sleep disorders
- ☐ Depression
- ☐ Psychological
- ☐ Eating disorder
- ☐ Drug/alcohol addiction
- ☐ Nicotine/caffeine addiction
- ☐ Hypoglycemia
- ☐ Varicose veins
- ☐ Blood clots
- ☐ Breathing difficulties/asthma
- ☐ Sinus problems
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Pacemaker
- ☐ Metal implants
- ☐ Currently pregnant
- ☐ Rashes
- ☐ Athlete's foot
- ☐ Warts
- ☐ Bladder problems
- ☐ Urinary tract infection
- ☐ Nausea/vomiting
- ☐ Gas/bloating/constipation
- ☐ Allergies/skin allergies
- ☐ Numbness/tingling
- ☐ Fatigue

If you checked any of the above, please explain:

18. Have you fallen in the last twelve months? ☐ Yes ☐ No

19. What else should we know that is pertinent to your treatment?

20. What goal would you like to achieve through therapy?

21. Do you exercise regularly? ☐ Yes ☐ No

If yes, what is your primary activity?

Patient Signature Date MM/DD/YYYY

Signature of Parent/Guardian Date MM/DD/YYYY