the HEALING PROJECT
PHYSICAL THERAPY
2028 Village Lane #203 • Solvang, CA 93463
Ph (805) 680-1246 • Fax (805) 697-0010 • marybeth@healingprojectpt.com
Mary Beth C. Johnson MPT - Physical Therapist

PATIENT INFORMATION FORM

Name_____ Date of Birth: _____
Address_____
City_____State_____ Zip Code_____
Home Phone # _____ Cell Phone # _____

Email:_____

The best way to contact me is (check one):○call○email○text

Male○ Female○ Other○ Marital Status _____
Emergency Contact Name :_____
Phone #: _____
Relationship to patient:_____
Referring Doctor:_____ Phone #_____

Insurance Information:
Primary:_____ID#_____

Secondary:_____ ID# _____

If you are <u>NOT</u> going through your insurance please select one of the following:

____ Workers Compensation
Name of Work Comp Insurance Company:_____
Adjuster name/ phone number:_____
Claim #_____

____ Self Pay

FINANCIAL POLICY

***Please read, initial and sign. If it has been a year from your last visit you will be asked to sign consent forms.**

***The following must be completed with credit card on file to be scheduled at The Healing Project Physical Therapy (EXCLUDING WORK COMP CASES)**

I, _____, authorize The Healing Project Physical Therapy, Inc. to charge the credit card indicated below for therapy service charges and NO SHOW fees that are on the account.

____ I understand that all copays and deductibles must be paid at the time of service. As part of our contract with the insurance payer we are legally required by the terms of the contract to collect copays and deductibles at the time of service.

___ I understand that THE HEALING PROJECT PHYSICAL THERAPY, INC. will submit a claim for the patient to the contracted insurance payer. **HOWEVER, ANY NON-COVERED SERVICES BY THE INSURANCE PAYER WILL BE THE PATIENT'S RESPONSIBILITY.**

___ I understand that the office requires a 24-hour cancellation notice. Failure to do so will result in a **$100 NO SHOW CHARGE PAYABLE BEFORE THE NEXT SCHEDULED VISIT**. This fee is not covered by your insurance.

___ I understand that it is mandatory to notify the billing office of any insurance or benefit changes immediately.

___ I understand that there will be a **$25 charge** for a returned check. This amount will be in addition to your open balance.

___ I understand that any outstanding balance over 90 days past due is considered delinquent. You will be sent a final notice letter to pay the account in full within 15 days. If any balance remains unpaid, we may defer the delinquent account to a collection agency and you may be discharged from the practice.

___ I consent to bill my health Insurance payer directly, or from another insurer for the services provided to me or my children under the age of 18 years old. This may include determination of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services for the purpose of reimbursement. This information may also be used for billing, claims management, collections and related health care data processing through this practice. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time. I have read and understand the payment policy of THE HEALING PROJECT PHYSICAL THERAPY, INC. and agree to abide by its policy guidelines.

Visa_____ Mastercard_____ American Express_____ Discover_____

Cardholder Name:_____

Credit Card Number:_____

Expiration Date:_____ Billing Zip:_____ CCV#_____

Billing Address:_____

City/State/Zip Code:_____

Patient/Guardian Signature:_____Date_____

INSURANCE PRIVACY PORTABILITY ACT - NOTICE OF PATIENT INFORMATION PRACTICES

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

LEGAL DUTY

The Healing Project Physical Therapy, Inc. 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 DISCLOSURES OF HEALTH INFORMATION

The Healing Project Physical Therapy, Inc. uses your personal health information primarily for treatment, any insurance carrier direct billing, obtaining payment for treatment, conducting internal administration activities and evaluating the quality of care that we provide. For example, The Healing Project Physical Therapy, Inc. may use your personal health 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.
The Healing Project Physical Therapy, Inc. 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 other situation, The Healing Project Physical Therapy, Inc. 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 this authorization to stop further disclosures at any time. The Healing Project Physical Therapy, Inc. may change its policy at any time. When changes are made, a new Notice of Patient Information Practices will be posted in the waiting room and patient exam room areas. A new copy of the Notice of Patient Information Practices will be available to you on your next visit or you may request an updated copy at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health Information at any time at no charge for the first time. However, you will be charged a $25.00 fee on the second request. 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 in which we have disclosed your personal health Information for reasons other than treatment, for any insurance carrier direct billing, for disclosure to physicians' offices and 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), or when required by law or in emergency circumstances. The Healing Project Physical Therapy, Inc. will consider all such requests on a case by case basis, but the practice Is not legally required to accept all requests.

DESIGNATION RIGHTS

You have the right to designate a person below to request and receive the release of any protected health information related to your treatment, payment or administrative operations. You understand that the identity of the designated person must be verified before the release of any information.

Name:_____Relationship: _____

Name:_____Relationship: _____

_____ _____

Patient/Guardian Signature Date

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AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Purpose: To assist all therapists during the course of my physical therapy treatments at this office.

I voluntarily consent to the release and disclosure of my personal health information to The Healing Project Physical Therapy, Inc.

(Patient to check the applicable box below only)

o All of my health information that the provider has in his or her possession.

o Exception: _____

I understand that the information outlined in this release will be disclosed according to the instructions of this release within two (2) business days of The Healing Project Physical Therapy, Inc. having received this release authorization. I understand that I am free to revoke this release authorization at any time by notifying the practice in writing. I also understand that the information disclosed under this release is subject to re- disclosure and no longer protected by the Privacy Regulations (45 C.F.R. 164). This authorization is valid for a 12-month period.

CONCERNS AND COMPLAINTS

If you are concerned that The Healing Project Physical Therapy, Inc. may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information or to file a complaint, please contact our administration office listed below. You may also send a written complaint to the US Department of Health and Human Services.

Inquiries to: The Healing Project Physical Therapy
2028 Village Lane Suite 203,
Solvang, CA 93463
Phone:(805) 680-1246, Fax: (805) 697-0010

Print Patient Name	Date of Birth
Patient/Guardian Signature	Date

Pain - please circle the appropriate level: **NAME:**_____

Pain level with activity: 0-1-2-3-4-5-6-7-8-9-10

Pain level at rest: : 0-1-2-3-4-5-6-7-8-9-10

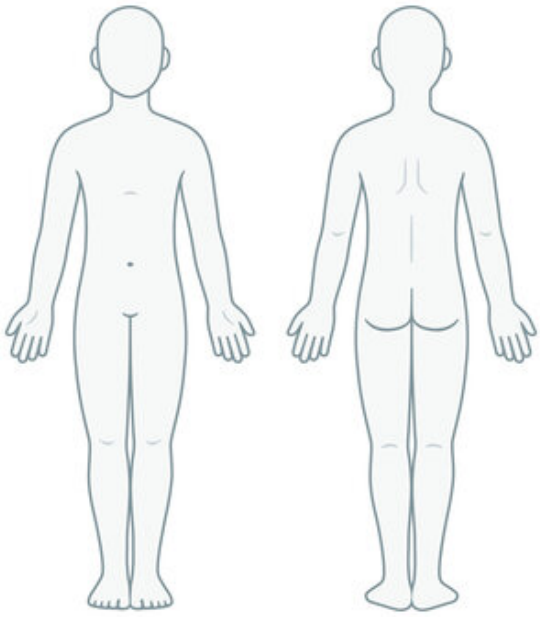
I describe my pain as (circle all that apply):

Burning	Tingling	Sharp	Dull Ache
Throbbing	Shooting	Numbness	Constant/Intermittent

Location: _____

Please draw your pain on this chart:

FRONT BACK



Positions that worsen my pain (circle all that apply)

Sitting	Standing	Walking	Lying down	Turning in bed	Kneeling	Squatting
Driving	Getting in/out of car	Bending at the waist	Lifting more than 5 pounds	Reaching overhead	Reaching behind back	Hygiene
Getting dressed	Cooking	Turning head while driving	Arising from a seated position	Stairs	Getting into/out of bed	Gripping

Other:_____

NAME:_____

Things that make my pain better (circle all that apply):

Ice	Heat	Rest	Exercise	Stretching
Medication	Lying Down	Standing	Sitting	

Other: _____

Medical History (circle all that apply):

Alzheimer's	Current Infection	High Blood Pressure	Lupus	Osteopenia Osteoporosis
Cardiovascular Disease	Diabetes Type 1	History of Cancer	Muscular Dystrophy	Parkinson's
Cauda Equina Syndrome	Diabetes Type 2	Huntington's	Obesity	Rheumatoid Arthritis
Stroke	Fibromyalgia	Immunosuppression	Osteoarthritis	Traumatic Brain Injury

Other: _____

My usual activities include (check all that apply):

Reading	Watching TV	Walking	Gardening
Housework	Occasional physical exercise	Regular physical exercise at least twice weekly	

Other:_____

Please list your medications (or bring in a list of your medications):

_____

_____

_____

_____

_____

My GOALS for therapy are _____

_____

_____

_____