MEDICARE REGISTRATION FORM

Mt. Eden Physical Therapy Center

Please make sure to address every line. This will help us bill your insurance correctly.

NAME_____Your Bithdate_____SS#__ __ __-__ __-__ __ __

MARTIAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

ADDRESS_____CITY_____ZIP CODE_____

HOME PHONE_____WORK_____CELL_____

EMAIL ADDRESS_____(please print clearly)

We will use your email address for appointment reminders

EMERGENCY CONTACT_____PHONE #_____RELATION_____

WHO IS YOUR REFERRING DOCTOR? Dr. _____

WHO IS YOUR PRIMARY DOCTOR? Dr._____

Please complete this section for your SECONDARY insurance

NAME OF INSURED_____BIRTHDATE_____RELATION_____

INSURED'S EMPLOYER_____

What problems are we treating you for today?_____

Have you had surgery for this problem? _____DATE OF SURGERY_____

DID YOU HAVE A NURSE, PHYSICAL THERAPIST, OCCUPATIONAL THERAPIST, OR SPEECH THERAPIST VISIT YOU AT YOUR HOME IN 2013?

If yes, have you been discharged from Home Care?

If yes, please provide the name of the agency_____

Have you had physical therapy anywhere else this year?	☐ YES	☐ NO
Do you have a pending or approved worker's comp claim?	☐ YES	☐ NO
Is this injury due to an auto accident?	☐ YES	☐ NO

Assignment of Benefits• Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Mt. Eden Physical Therapy Center (Provider 1386620953), and any assisting medical professionals, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay interest as stated on the financial policy and clerical costs associated with collections including postage. I hereby authorize this heath care provider to release all information necessary to secure payment of benefits and management of my care.

I further agree that a photocopy or print of the scanned original of this agreement shall be as valid as the original.

Sign_____Date_____

MT. EDEN PHYSICAL THERAPY CENTER

PATIENT HISTORY QUESTIONNAIRE

Please fill this out to the best of your ability, and just ask us if you have any questions....thank you!

Name:_____ Age:_____ Occupation:_____

1. When did your present problem start?

_____
_____
_____

Are you still working? □ Yes □ No
If no, last day on job _____

2. How did your pain or problem start?

□ Suddenly
□ Gradually
□ Lifting
□ Twisting
□ Fall
□ Bending
□ Pulling
□ Injured at work
□ Injured in auto accident
□ Hit from behind
□ Injured during sports
□ No apparent cause

3. What activities make the pain worse?

□ Sitting
□ Standing
□ Walking
□ Coughing
□ Sneezing
□ Exercise (during)
□ Exercise (after)
□ Bending forward
□ Bending backward
□ Not known

4. What reduces the pain?

□ Lying down
□ Sitting
□ Standing
□ Walking
□ Manipulation
□ Chocolate
□ Exercises/stretching
□ Injections
□ Anti-inflammatory pills
□ Aspirin
□ Pain pills
□ Nothing

5. Have you had any of these diagnostic tests?

□ X-rays Date_____
□ CT Scan Date_____
□ EMG (electromyogram) Date_____
□ MRI Date_____
□ Injections Date_____

6. Have you been hospitalized for this problem?

□ Yes □ No Number of times _____

7. Please list any other major surgeries:

_____
_____
_____
_____
_____
_____

8. Do you have any of these conditions?

□ Stomach problems
□ Diabetes
□ Arthritis
□ Gout
□ Bowel/Bladder
□ Other _____
□ Cancer
□ Heart
□ Epilepsy
□ Weight loss
□ Seizures

9. Please list any allergies:

_____
_____

10. Do you smoke cigarettes?

□ Yes □ No How much? _____

11. What other types of doctors or health care providers have you seen for this?

_____
_____
_____

12. Please list your medications:

_____
_____
_____
_____
_____

MEDICARE PATIENTS:

Is anyone, including a nurse, physical therapist or occupational therapist, coming to your home? Medicare will not pay us, if you are not discharged from home care.

□ **YES** □ **NO**

If you are having **PAIN**, please fill out the back of this form.

PAIN QUESTIONNAIRE

Name_____ Date_____

How bad is your pain now?

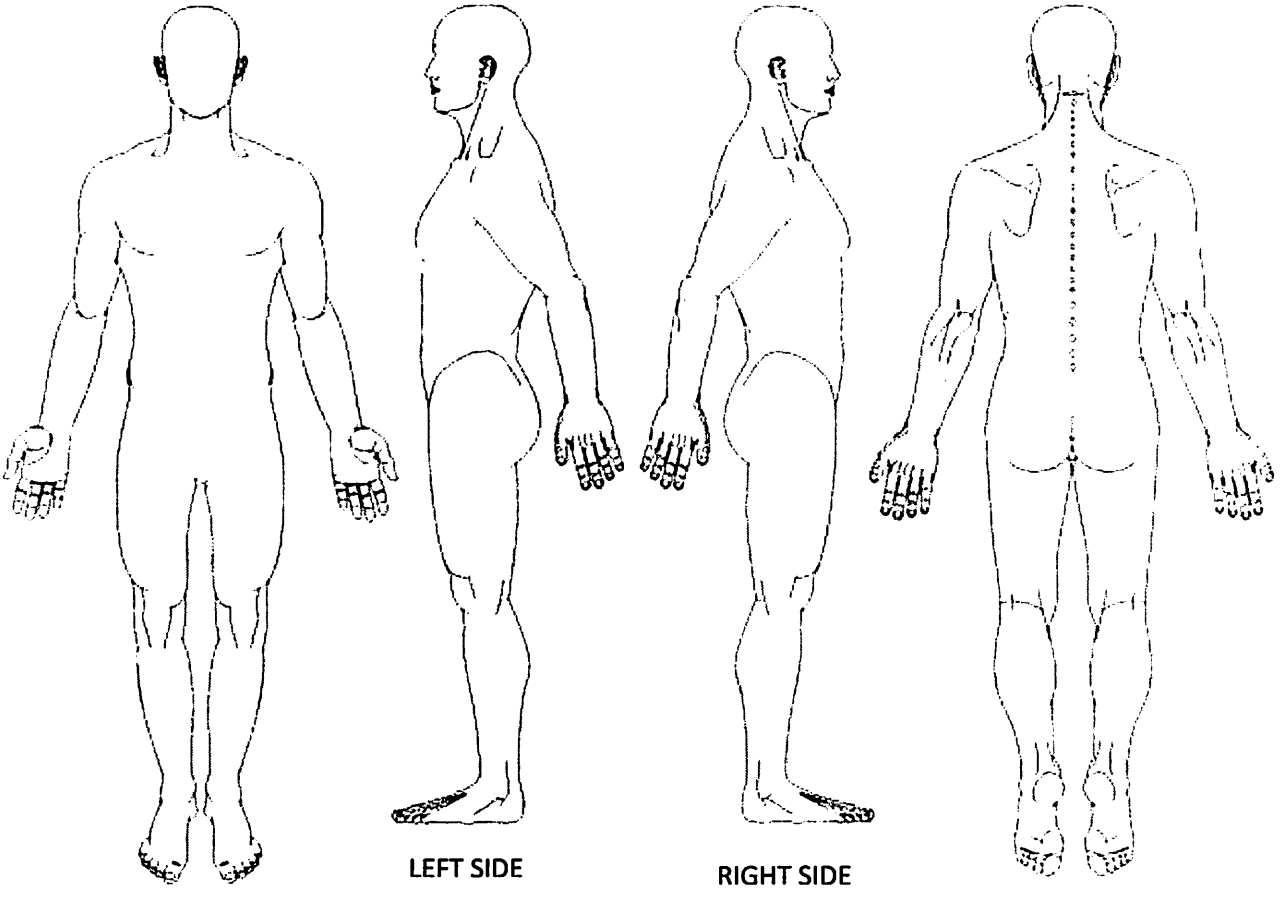
Please mark the line below with an "X"

No pain at all_____Worst Possible Pain

Where is your pain now?

Mark the areas on your body where you feel the sensations described below, using the appropriate symbol(s).

Aching	Numbness	Pins and Needles	Burning	Stabbing
▲▲▲▲	= = = =	O O O	X X X	/ / / /



FRONT LEFT SIDE RIGHT SIDE BACK

MT. EDEN PHYSICAL THERAPY CENTER

19845 LAKE CHABOT ROAD SUITE 205, CASTRO VALLEY CA 94546

PHONE (510) 538-9558 FAX (510) 538-7017

FINANCIAL POLICIES AND REGULATIONS

- All charges are your responsibility, whether or not you have medical insurance.
- Any co-payments and unpaid deductibles are due at the time of each treatment.
- We will charge your account $50 for any returned checks.
- If your account is delinquent: Any medical insurance contractual discounts previously taken will be voided. We will add postal costs to your account. A finance charge of 10% interest per year or minimum of $1.50 per month will be charged to delinquent accounts. Your account will be charged $5 each time we must re-bill you for an unpaid balance. This does not apply to the first billing. Payments on account are due within two weeks of the billing date.

APPOINTMENTS

We try hard to stay on time and on schedule. If you are going to be late, please call and notify our office as soon as possible.

CANCELLATIONS or MISSED APPOINTMENTS

If you have to cancel or reschedule an appointment, please give a 24-hour notice.

A $75 fee will be charged on visits missed or cancelled without a 24-hour notice if it cannot be rescheduled within 24 hours. If you have more than two no-shows and/or multiple cancellations, any future appointments may be automatically cancelled and those times given to other patients. Missing appointments may adversely affect your response to treatment. Please be aware that if you are a WORKERS' COMPENSATION patient, multiple no-shows and cancellations will jeopardize your worker's comp claim, as this may be a sign of non-compliance to your carrier.

INFORMED CONSENT, ASSIGNMENT OF BENEFITS, ACKNOWLEDGEMENT OF RECEIPT OF YOUR PATIENT RIGHTS AND AGREEMENT TO PAY

- I have read the above policies, understand them and agree to abide by them.
- I acknowledge having received and have read my rights as a patient, and I consent to receive treatment, in accordance with my physician's prescription.
- I authorize release of any information regarding my treatment in this facility to my referring physician, my insurance company, or a medical equipment provider.
- I hereby assign all medical benefits to MT. EDEN PHYSICAL THERAPY CENTER and its providers.
- A photocopy or scanned copy of this assignment and agreement is to be considered as valid and legally binding as the original.

Signature_____ Date_____

Please print your name_____