REGISTRATION

(PLEASE PRINT)

HARBOR PHYSICAL THERAPY
& SPORTS MEDICINE
1294 WEST SIXTH STREET, SUITE 101
SAN PEDRO, CALIFORNIA 90731

PATIENT INFORMATION

Today's Date________ DOI/DOA ________ Home Phone ________ Cell Phone________

Name ________ (Last Name) (First Name) (Initial) Soc. Sec. # ________

Address ________ Email ________

City ________ State ________ Zip ________

Sex ☐M ☐F Age ____ Birthdate ________ ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Patient Employed by ________ Occupation ________

Business Address ________ Zip Code ____ Business Phone ________

Whom may we thank for referring you? ________

In case of emergency, who should be notified? ________ Phone ________

PRIMARY INSURANCE — RESPONSIBLE PARTY

Person Responsible for Account ________ (Last Name) (First Name) (Initial)

Relation to Patient ________ Birthdate ________ Soc. Sec. # ________

Address (if different from patient's) ________ Phone ________

City ________ State ________ Zip ________

Responsible Party Employed by ________ Occupation ________

Business Address ________ Business Phone ________

Insurance Company ________

Contract # ________ Group # ________ Subscriber # ________

ADDITIONAL INSURANCE

Is patient covered by additional insurance ☐Yes ☐No

Subscriber Name ________ Relation to Patient ________ Birthdate ________

Address (if different from patient's) ________ Phone ________

City ________ State ________ Zip ________

Subscriber Employed by ________ Business Phone ________

Insurance Company ________ Soc. Sec. # ________

Contract # ________ Group # ________ Subscriber # ________

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with ________ (Name of Insurance Company(ies))

and assign directly to Harbor Physical Therapy & Sports Medicine all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

________ Responsible Party Signature   ________ Relationship   ________ Date

HARBOR PHYSICAL THERAPY & SPORTS MEDICINE

PATIENT NAME: ______________________________ DATE: ______________

AGE: ______ PRIVATE M.D.: ______________ REFERRING M.D.: ______________

MEDICAL HISTORY: HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING:

	YES	NO		YES	NO
FRACTURES	___	___	RESPIRATORY ILLNESS	___	___
DIABETES	___	___	ALLERGIES	___	___
HEAD TRAUMA/ CONVULSIONS	___	___	HIGH BLOOD PRESSURE	___	___
VASCULAR DISEASE	___	___	KIDNEY DISEASE	___	___
STROKE	___	___	RHEUMATIC DISEASE	___	___
METAL IMPLANTS	___	___	DENTURES	___	___
PACEMAKER	___	___	HEART ATTACK	___	___
BLOOD DISEASE	___	___	CANCER(S)	___	___
HERNIAS	___	___	BOWEL/BLADDER PROBLEMS	___	___
CHANGE IN BODY WEIGHT	___	___			

WOMEN:
ARE YOU CURRENTLY PREGNANT? ___Y ___N

PAST SURGERIES:

____

CURRENT MEDICATION(S):

____

ARE YOU USING A BRACE OR SUPPORT? ___Y ___N

PATIENT SIGNATURE: ______________________________ DATE: ____________

Harbor Physical Therapy and Sports Medicine
1294 West 6th Street, Suite 101
San Pedro, California 90732
(310) 547-1850

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of this Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders: We may disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.15 for each page, $20.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

Contact:	Carol Wright
Telephone:	(310) 547-1850
Fax:	(310) 547-1972
Address:	Harbor Physical Therapy 1294 W. 6th Street, San Pedro, California 90744

HARBOR PHYSICAL THERAPY AND SPORTS MEDICINE

1294 West 6TH Street Suite 101, San Pedro, California 90732

Print Name: ______________________________ **Date:** ___________

Please help us make your treatment as effective and consistent as possible. The following parameters pertain to your insurance company.

PRIVATE INSURANCE ONLY

For an insurance company to establish payment responsibility as well as to establish medical necessity, a current prescription/referral is required. ***Your prescription/referral begins on the date it was written by the referring physician, not on the day you begin/continue physical therapy.*** It is your responsibility to ensure that we have a current prescription/referral on file. **Initial Here:** __________

MEDICARE PATIENTS ONLY

Medicare requires patients to "be seen" by their referring physician every 30 days in order to obtain a new prescription/referral for continued physical therapy. According to Medicare guidelines, your prescription/referral begins on the date it was written by the referring physician, not on the day you begin/continue physical therapy.

As of January 1, 2008, Medicare will cap outpatient rehabilitation coverage, combining Physical Therapy AND Speech Therapy, at **$1,810** per beneficiary for the calendar year. Keep in mind that the **$1,810** includes both the amount Medicare pays and the beneficiary co-payment. Once you've hit the cap amount, you can either pay out of pocket for your services at our facility or receive physical therapy services in an outpatient hospital setting. **Initial Here:** __________

In order to be compliant with these guidelines, please provide the following information:

Have you received PHYSICAL THERAPY and/or SPEECH THERAPY this calendar year? ☐ **YES** ☐ **NO**

If **YES**, at what facility did you receive these services? ________________________

In order to be eligible for outpatient physical therapy services, under Medicare Part B, you must not live in a skilled nursing facility.

Are you currently living in a skilled nursing facility? ☐ **YES** ☐ **NO**

In addition, under Medicare Part B, you are not eligible to receive outpatient physical therapy services in the same month that you have received Home Health Services/in Home Physical Therapy.

Have you received Home Health Services/in Home Physical Therapy this month?

YES ☐ **NO**☐ If YES, please provide us with your discharge date: __________

HARBOR PHYSICAL THERAPY AND SPORTS MEDICINE

1294 West 6TH Street Suite 101, San Pedro, California 90732

Print Name: ____

1. CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION TO INSURANCE CARRIER.

I, the undersigned, do hereby agree and give my consent for Harbor Physical Therapy and Sports Medicine to furnish medical care and treatment considered necessary and proper in the diagnosis and treatment of my physical condition. **Initial Here:** ______

2. ASSIGNMENT OF BENEFITS

I hereby authorize release of medical information necessary to file a claim with my insurance company (PPO, POS, HMO, WORKER'S COMPENSATION) and assign benefits otherwise payable to me to Harbor Physical Therapy and Sports Medicine. I understand that I am financially responsible for any balance not covered by my insurance carrier. **Initial Here:** ______

3. RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Harbor Physical Therapy and Sports Medicine's Notice of Privacy Practices. **Initial Here:** ______

4. CANCELLATION POLICY

Please call if you must cancel your appointment so that we may accommodate other patients if need be. Patients with morning appointments are required to cancel by 4:00 p.m. the previous day. Those with afternoon appointments are required to cancel by 10:00 a.m. the same day. Failure to do so will result in a missed appointment charge of $35.00 billed directly to you. **Initial Here:** ______

5. CONSENT TO SHARE MEDICAL AND/OR BILLING INFORMATION.

In the event that our office staff may need to discuss medical or billing issues with you or your family, please provide the name(s) of those with whom we may speak. This will allow us to maintain your privacy.

1. ______________________________ **2.** ______________________________

I acknowledge that I have read and understand the above information.

______________________	______________________	__________
Signature	Relationship to Patient	Date
	______________________	__________
	Signature of Witness	Date