BioMechanics Physical Therapy

Premier Service, Reliable Therapy, Elite In-Home Care

Patient Registration

1. Patient Info

First Name _____ Last Name _____ Date of Birth _____ ☐ Male ☐ Female

Street Address _____ City _____ State CA Zip Code _____

Home Phone _____ Cellular _____ Email _____

Emergency Contact (First Last) _____ Cellular _____ Relationship _____

My Injury / Condition / Diagnosis: _____ Onset Date _____ Surgery: _____ Surgery Date _____

2. Referral Info

Referring Physician Name: _____ Phone _____ Fax _____

Follow Up Date _____ Email _____

Primary Physician Name: _____ Phone _____ Fax _____

Follow Up Date _____ Email _____

3. Treatment Consent

☐ I have been informed of the treatment considered necessary and I authorize this treatment as prescribed by my physician, or directed under California "Direct Access".

☐ I understand that as part of my treatment I will be engaging in physical activity and there is an inherent risk of injury, complication of my condition, or even death. I am voluntarily participating in these activities and freely assume these risks.

☐ I understand that the results are not guaranteed and I have the right to discuss the purpose and risks associated with all recommended treatment procedures or activities with my therapist and I may decline to participate at any time.

4. Privacy Notice

Biomechanics Physical Therapy, P.C. (BMPT) may disclose your protected health information within our practice for the purpose of treatment, payment, or healthcare operations. Specifically:

1. To insurance providers or designated payer for payment.
2. To comply with State Worker's Compensation Law's.
3. To notify family or other person responsible for your care in emergency or death.
4. To public health authorities to prevent or control disease, injury, child or elder abuse or neglect, domestic violence, or Food and Drug Administration for problems with products and reactions to medication and reporting disease or infection exposure.
5. For administrative or judicial proceeding.
6. To law enforcement official for any law enforcement purposes.
7. To organizations involved in procuring, banking, or transplanting organs and tissues.
9. To appropriate persons in order to prevent or lessen imminent threat to health or safety or a particular person or general public.
10. For Military, National Security, Prisoner, and Government benefits purposes.
11. To schedule we may leave appointment time on a recorded device.
12. In the event we are sold or merged with another organization your PHI will become the property of the new owner.
13. You may request but not guaranteed by BMPT to place restrictions on certain uses and disclosures.
14. You may have your PHI communicated through another method or location with written request.
15. You may inspect, copy, and request we amend your PHI. If denied we will included a reason why and how to disagree with the denial.
16. You have the right to receive accounting of disclosures of your PHI by us.
17. You have the right to have a paper copy of this privacy notice.
18. We reserve the right to amend this notice at any time and it will be effective for all information that it maintains. We are required to comply with this Notice.
19. If you have questions or complaints about your privacy rights or our duties please call (323-786-1890) if our Officer is not available we will schedule a phone conference within 2 days.
20. If you are not satisfied you may submit a formal complaint to : DHHS, Office of Civil Rights 200 Independence Avenue, S.W. Room 509F HHH building Washington, DC 20201
21. I have read and understand my privacy rights. I consent for BMPT to use my PHI for treatment, payment, and healthcare operations.

5. Payment Choice & Financial Responsibility

☐ I am understand I may go to a clinic and use my insurance. Or if I am home bound I may utilize my insurance to have home health therapy services. I have chosen to pay cash with my credit card at a rate of $200 per visit in order to have therapy in the convenience of my home.

☐ I am home bound and I want to utilize my insurance to bill for my services. I will notify Biomechanics immediately to connect me with an appropriate provider.

☐ I want to use my insurance and I am not home bound I will continue with an outpatient service.

☐ I agree that I am responsible for any and all remaining balances including but not limited to costs associated with collecting account balance such as court costs, attorney's fees, and or collection agency commissions or charges.

☐ I agree that I will be signing my name each time a therapists visits me. This signature is my proof for services rendered and allows BioMechanics Physical Therapy, P.C. to bill my credit card on file for those services provided.

☐ Visa ☐ MC ☐ AMEX ☐ Discover Card Number: _____

Name of Card Holder: _____ Exp. Date: _____ CVV Code: _____

_____ _____

Patient Signature/ Guardian/ Representative Date Biomechanics Representative Date

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