STAR PHYSICAL THERAPY

1779 WOODSIDE ROAD, SUITE 102 REDWOOD CITY, CA 94061
650-780-9700/FAX: 650-780-0225

REGISTRATION FORM

(PLEASE PRINT)

PATIENT INFORMATION

PATIENTS NAME: _____
(FIRST) (MIDDLE) (LAST) (DATE OF BIRTH)

STREET ADDRESS: _____

_____
(CITY) (STATE) (ZIP CODE)

CONTACT INFORMATION: _____
(HOME PHONE) (CELL) (WORK)

EMAIL ADDRESS: _____

OTHER FAMILY MEMBERS SEEN HERE: _____

EMERGENCY CONTACT: _____PHONE #: _____RELATION: _____

INSURANCE INFORMATION

(PLEASE GIVE RECEPTIONIST YOUR INSURANCE CARD)

PRIMARY INSURANCE CARRIER: _____
(CARRIER) (SUBSCRIBER NUMBER) (GROUP NUMBER)

RELATIONSHIP TO SUBCRIBER: ☐ SELF ☐ SPOUSE/PARTNER ☐ CHILD ☐ OTHER (CHECK ONE)

SUBSCRIBERS DATE OF BIRTH: _____/_____/_____

SECONDARY COVERAGE: _____
(CARRIER) (SUBSCRIBER NUMBER) (GROUP NUMBER)

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to STAR PHYSICAL THERAPY. I understand that I am financially responsible for any balance. I also authorize STAR PHYSICAL THERAPY to release any information required to process my claims within the guidelines of the HIPPA Patient Privacy Laws. I understand that there will be a missed appointment charge of $25 for failure to give 24 hours notice.

_____ _____
(PATIENT/GUARDIAN SIGNATURE) (DATE)

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MEDICAL HISTORY

Please check if you have ever had or currently have any of the following:

Heart			Lung Disease		
Congestive Heart Failure	Yes	No	Chronic Obstructive Pulmonary Disease	Yes	No
High Blood Pressure	Yes	No	Emphysema	Yes	No
Heart Attack (MI)	Yes	No	Asthma	Yes	No
Atherosclerotic Disease	Yes	No	Recent Pneumonia	Yes	No
Angioplasty	Yes	No		Yes	No
Valvular Disease	Yes	No	Vascular Disease		
Stents	Yes	No	Peripheral Arterial Disease	Yes	No
Arrhythmia	Yes	No	Acquires Respiratory Distress Syndrome	Yes	No
Coronary Artery Bypass Graft	Yes	No	Diabetes		
Angina	Yes	No	Stroke/TIA		
Pacemaker	Yes	No			
General Medical			**General Medical**		
Allergies	Yes	No	Multiple Sclerosis	Yes	No
Headaches	Yes	No	Parkinson's Disease	Yes	No
Visual Impairment	Yes	No	Other Neurological	Yes	No
Hearing Impairment	Yes	No			
			Gastrointestinal Disease	Yes	No
Anxiety/Panic Disorders	Yes	No	Ulcer	Yes	No
Depression	Yes	No	Hernia	Yes	No
Sleep Dysfunction	Yes	No	Acid Reflux	Yes	No
Dizziness/Fainting					
Hepatitis	Yes	No	Kidney/Bladder Problems	Yes	No
AIDS	Yes	No	Incontinence	Yes	No
Arthritis	Yes	No	Cancer	Yes	No
Osteoporosis	Yes	No	Chemotherapy	Yes	No
			Radiation	Yes	No
Prosthesis/Implants	Yes	No			

Other Medical Condition : _____

Past General Surgery: _____

Past Orthopedic Surgery : _____

- **If YES to any of the above, please explain:** _____

  _____

- **List any medications you are currently taking:** _____

  _____

- **Please describe any known allergies:** _____

  _____

- **Have you had Physical Therapy for this condition before?** _____

  _____

- **If yes, approximately when and where:** _____
- **Have you been recently hospitalized?** _____
- **Are you currently receiving Home Health Care? (i.e. nursing care or therapy) :** _____
- **What other therapies/ have you tried?(Chiropractic/Acupuncture/Aquatic Therapy):** _____

  _____

- **Is today's therapy related to an accident or work related injury?**_____

_____ _____

PATIENT SIGNATURE **DATE**

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PATIENT POLICY STATEMENT

Dear Patient:

We are pleased to serve you and hope your recovery will be speedy. The following policy enables us to provide you with your prescribed therapy treatment:

1) In order to respect and not interfere with other patients' treatment, physical therapy is provided on an APPOINTMENT BASIS ONLY.

- **As a courtesy, we ask that 24 hours notice be given for cancellation of an appointment. A missed appointment charged of $25 will be billed to you if appropriate notice is not given.**
- **Failure to arrive within 15 minutes of your scheduled appointment time may result in the inability to provide services to you that day.**

2) As a courtesy, S.T.A.R. Physical Therapy will submit Billing to your PRIMARY insurance carrier. In the case of SECONDARY coverage, S.T.A.R. Physical Therapy will provide the patient with appropriate claim forms. However, it will be the responsibility of the patient to collect from their secondary. All secondary balances are expected to be paid promptly, regardless of secondary carrier reimbursement.

3) Due to insurance liability and confidentiality reasons the gym area is restricted to patients and legal guardians only.

4) To respect others, CELL PHONE USAGE IS PROHIBITED, UNLESS DEEMED AN EMERGENCY.

If you should have any questions regarding this policy statement, please do not hesitate to contact the business office.

I have reviewed and understand this policy statement and agree to comply fully with this policy.

_____ _____

Signature of Patient or Guardian of Minor **Date**

S.T.A.R. PHYSICAL THERAPY
NOTICE OF HIPAA PRIVACY PRACTICES

Effective January 1, 1997

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

Disclosure of your health care information

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with S.T.A.R. PHYSICAL THERAPY."

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations. "As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to *S.T.A.R. PHYSICAL THERAPY* for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized bill for you to submit upon request. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services rendered.

Workers' Compensation
We may disclose your health information as necessary to comply with State Workers Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons
We may disclose your health information to coroners or medical examiners.

Organ Donation
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

S.T.A.R. PHYSICAL THERAPY
NOTICE OF HIPAA PRIVACY PRACTICES

Effective January 1, 1997

Privacy Practices Continued

Specialized Government Agencies
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Contacting the patient
We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment. Your email address may be used to contact you for appointments as well.

Your Health Information Rights

- **You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that *S.T.A.R. PHYSICAL THERAPY is not required to agree to the restriction that you requested.***
- **You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.**
- **You have the right to inspect and copy your health information.**
- **You have a right to receive an accounting of disclosures of your protected health information made by S.T.A.R. PHYSICAL THERAPY**
- **You have a right to a paper copy of this Notice of Privacy practices at any time upon request.**

Changes to this Notice of Privacy Practices
We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

S.T.A.R. PHYSICAL THERAPY is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice, complaints or if you want more information about your privacy rights, please contact:

Charles Cody Managing Partner
1779 Woodside Road Suite 102
Redwood City, CA 94061
650-780-9700

if you are not satisfied with the manner in which your complaint was handled by our office, please contact DHHS, Office of Civil Rights 200 Independence Ave. S.W. Room 509F HHH Building, Washington, DC 20201

By way of my signature, I provide S.T.A.R. PHYSICAL THERAPY with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

****The Privacy Laws are yours to keep. Please see next page for signature page.**

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NOTICE OF HIPAA PRIVACY PRACTICES

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I have read the Privacy Notice and understand my rights contained in the notice.

Patient Name: _____
(Please Print)

Patient Signature: _____

Date: _____

Parent or Guardian Signature: _____

OFFICE USE ONLY BELOW

Signature of Staff: _____

Date: _____

Good Faith effort to obtain receipt:

Explain:_____