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: _____

REFERRING PHYSICIAN: _____

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

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 $50 for failure to give 24 hours notice.

_____ _____
(PATIENT/GUARDIAN 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 $50 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**

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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	Yes ☐	No ☐
Stents	Yes ☐	No ☐	Peripheral Arterial Disease	Yes ☐	No ☐
Arrhythmia	Yes ☐	No ☐	Acquires Respiratory Distress Syndrome	Yes ☐	No ☐
Coronary Artery Bypass Graft	Yes ☐	No ☐	Diabetes	Yes ☐	No ☐
Angina	Yes ☐	No ☐	Stroke/TIA	Yes ☐	No ☐
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	Yes ☐	No ☐			
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 Conditions: _____

Past General Surgery: _____

Past Orthopedic Surgery : _____

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

_____

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 for this condition? (Chiropractic/Acupuncture/Aquatic Therapy):

_____

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

Are you currently taking blood thinners or anticoagulant medications? _____

Medication list:

NAME	DOSAGE/FREQUENCY PRECRIBED	PHYSICIAN

_____ _____

PATIENT SIGNATURE **DATE**

HIPAA AND PRIVACY PRACTICES

If you have any questions or requests, please contact Howard Lieberman at 650-780-9700.

Uses and Disclosures

Treatment.
Your health information may be used by staff members to disclose to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations.
Your health information may be used as necessary to support the day to-day activities and management of STAR Physical Therapy, Inc. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement.
Your health information may be disclosed to law enforcement agencies to support government audits and inspection, to facilitate law enforcement investigations, and to comply with government-mandated reporting.

Public health reporting.
Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization.
Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use of disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you revoked your authorization.

Additional Uses of Information Appointment reminders.
Your health information may be used by our staff to send you appointment reminders. Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights You have certain rights under the deferral privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

STAR Physical Therapy
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our front office receptionists or Howard Lieberman. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints.
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

STAR Physical Therapy
c/o Howard Lieberman
1779 Woodside Road, Suite 102
Redwood City, CA 94061

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

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.

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

Effective January 1, 1997

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:_____