

**NEW PATIENT REGISTRATION FORM**

Please give your insurance card(s) to the receptionist for copying. Thank you.



Name: \_\_\_\_\_ Date: \_\_\_\_\_  
First MI Last

Home address: \_\_\_\_\_  
Street City State Zip code

Mailing address: \_\_\_\_\_  
 (if different from above) Street City State Zip code

Home phone: (w/area code) \_\_\_\_\_ Cell phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Date of Birth:

Gender:  Male  Female  
 Marital Status:  Single  Married  Divorced  Widowed

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Date of Next Appointment: \_\_\_\_\_

**INSURANCE**

**PRIMARY Insurance:** \_\_\_\_\_ **Insured's Name:** \_\_\_\_\_ **Insured's DOB:** \_\_\_\_\_

Insured address (if different from above): \_\_\_\_\_

**Policy ID#:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**SECONDARY Insurance:** \_\_\_\_\_ **Insured's Name:** \_\_\_\_\_ **Insured's DOB:** \_\_\_\_\_

Insured address (if different from above): \_\_\_\_\_

**Policy ID#:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Motor Vehicle Accident or Workers' Comp Patients ONLY**

**Date of accident:** \_\_\_\_\_  Work  Auto—please specify location of accident, if other than Oregon: \_\_\_\_\_

**Employer name and phone:** \_\_\_\_\_ **Soc Sec #:** \_\_\_\_\_

Employer address: \_\_\_\_\_ **Claim #:** \_\_\_\_\_

Name of Insurance co. (workers' comp or auto PIP) \_\_\_\_\_

Insurance co. address: \_\_\_\_\_

Adjuster name: \_\_\_\_\_ Adjuster phone: \_\_\_\_\_

Name of insured: \_\_\_\_\_ Name of lawyer and phone: \_\_\_\_\_

**Please tell us how you learned of our services or whom we can thank:**  
 Former patient  Doctor recommendation  Insurance company recommendation  
 Former patient recommended you (name) \_\_\_\_\_  
 Family/friend recommended you (name) \_\_\_\_\_

Are you currently enrolled in Hospice, Home Health or Inpatient Physical Therapy?

I acknowledge that the above information is true and correct. I hereby authorize treatment and understand the possible benefits and risks of my treatment. I understand that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services.

**X SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

check here if you would like to receive info/updates/class information via email from us.  
 (We do not share email addresses with anyone under any circumstances).



## CONSENT FOR ACUPUNCTURE/ASIAN MEDICINE TREATMENT

I, the undersigned, voluntarily consent to the use or disclosure of my protected health information by Focus Physical Therapy, Inc. for the express purpose of providing treatment, obtaining payment for my health care costs or to conduct health care operations. I understand that treatment may be conditional upon my consent.

I understand that I have the right to request a restriction as to how my protected health information is utilized or disclosed in order to carry out treatment, receive payment or other health care operations of the clinic. Focus is not obligated to agree to my stated restrictions. I understand that should Focus agree to my stated restrictions that it will be binding on Focus and my acupuncturist. I have the right to revoke this consent in writing, at any time, except to the extent that my acupuncturist and Focus have taken action in reliance on this consent.

My protected health information consists of any health information, including my demographic information, collected from me and created or received by my acupuncturist, other health care providers, a health plan, my employer, or a health care clearinghouse. This protected health information may relate to my past, present or future physical or mental health or any other condition that identifies me, or when there is a reasonable basis to believe the information may identify me.

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

I have personally received a copy of the Notice of Privacy Practices prior to signing this Consent for Acupuncture/Asian Medicine Treatment. This notice describes the variety of uses and disclosures of my protected health information that may occur during my treatment with Focus. The notice also outlines my rights and responsibilities with respect to my protected health information. I understand that Focus has the right to alter their Notice of Privacy Practices at any time. When changes are made to the policy, Focus will notify me in writing upon my next visit.

I hereby authorize Focus to administer treatment as is necessary. I also certify that no guarantee or assurance has been made as to the results that may be obtained. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance directly to me and that I am personally responsible for the payment.

I hereby authorize the insurance company/insurance administrator to pay by check or electronic funds transfer (EFT) and for it to be mailed directly to Focus the expense benefits allowable, and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered, and I have agreed to pay, in a current manner, any balance of professional charges.

I direct my attorney to pay any outstanding expenses from my settlement, and in effect, protect any such balance. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the acupuncturist's additional protection and consideration for his/her awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover. I have been advised that if my attorney does not wish to cooperate in protecting this physical therapist's interest, the physical therapist will not await payment, but require me to make payment on a current basis.

I understand that Acupuncturists (Lac) and massage therapists (LMT) practicing in the state of Oregon are not primary care providers. Focus recommends that all patients have a regular primary care physician. All patients must provide medical records from a primary care provider upon request.

Acupuncture is performed by the insertion of needles through the skin and/or by the application of heat to the skin at points on or near the surface of the body to treat bodily dysfunction or disease, to modify or prevent pain perception, and to normalize the body's physiological function. I understand that there may occasionally be adverse side effects such as local bruising, minor bleeding, fainting, pain or discomfort, the possible aggravation of symptoms existing prior to acupuncture treatment and very rare lung puncture (pneumothorax).

I am aware that the use of direct moxibustion therapy may present a risk of burning or scarring.

Electro-acupuncture may be administered with the acupuncture. I understand there may be certain adverse side effects such as electric shock, pain or discomfort and the possible aggravation of symptoms existing prior to treatment.

Chinese herbs and substances may be recommended to treat bodily dysfunction of disease or to modify or prevent pain perception and to normalize the body's physiological function. Patients must follow the directions for administration and dosage. I understand that there may occasionally be adverse side effects such as changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. I will discontinue use and contact my acupuncturist at once should any symptoms develop.

Acupressure-massage is used to modify or prevent pain perception and to normalize the body's physiological function. I understand that there may be certain side effects such as muscle soreness/tenderness and the possible aggravation of symptoms existing prior to treatment.

I authorize Focus to administer care as deemed appropriate and necessary to my dependent minor named:

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**Signature of Patient or Responsible Party**

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**Date**

## FINANCIAL POLICY



Welcome to Focus Physical Therapy, Inc.! In an effort to make ensure your rehabilitation and treatments with Focus are as stress free as possible we have established a clear financial policy. Below outlines information specific to all aspects of the financial responsibility associated with your recovery. Please read carefully and sign where indicated. A copy of this form will be issued to you upon request.

Focus partners with most regional insurance plans. If you are not insured by a plan that we conduct business with payment in full will be expected at each visit. All patients are encouraged to contact their insurance provider for verification or clarification of allowed benefits. Knowing your insurance benefits is your responsibility. In most cases, Focus will bill your provider, however any account balance incurred with Focus is legally your responsibility. The adult, parent or legal guardian accompanying a minor dependent is financially responsible for all services rendered by Focus and agree to all terms listed herein.

If Focus will be billing a workers' compensation carrier or motor vehicle insurance provider it is imperative that we receive your claim information as quickly as possible. We will also require a copy of your personal insurance information in the event that your workers' compensation or motor vehicle accident claim is denied.

Should your account become overdue our policy is to turn the account over to a collection agency. Any legal fees paid to secure overdue balances will be added to your account and treatment with our facility may be terminated.

### ***Terms of Agreement***

I, the undersigned, hereby agree with the following:

- All co-payments and deductibles must be paid at the time of service. This arrangement is part of my contract with my insurance company. Failure on the part of Focus to collect co-payments and deductibles from patients may be considered fraudulent. I agree to pay my co-payment and/or deductible at each visit.
- I am aware that some, and perhaps all, of the services/equipment I have received may be non-covered, denied by my carrier or not considered reasonable or necessary by Medicare or other providers. I understand that I am financially responsible for all charges not paid by my insurance company.
- I will present a copy of a current, valid insurance card to provide proof of my existing insurance coverage. I will notify Focus of any change in my information, including but not limited to, address, phone number or insurance coverage.
- My insurance company may need for me to supply certain information directly. It is my responsibility to comply with all requests. I am aware that insurance coverage does not guarantee payment of services.
- I certify that I (or my dependent) have insurance coverage as provided to Focus and assign directly all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by my insurance provider. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.
- I understand that I may be assessed a charge of \$35 for missed appointments not cancelled within 24-hours of my scheduled appointment time. These charges are my responsibility and not covered by my insurance.

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**Signature of Patient or Responsible Party**

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**Date**



## CANCELLATION POLICY

Thank you for choosing Focus Physical Therapy, Inc. for your care! We pride ourselves in our expert team and specialized care and will tailor your treatment to your specific needs in each one-on-one, hour long appointment. Your appointment time was scheduled exclusively for you and in an effort to best accommodate your schedule. As a result of the time and energy placed into your treatment plan, we require a 24-hour cancellation notice.

Emergency situations and personal illnesses do occur that may make it impossible to keep a scheduled appointment. In those instances, we will not charge you the missed appointment fee of \$35. Please be advised that a second cancellation of an appointment outside of the required 24-hour notice period will result in a fee of \$35. The cancellation fee is not billable to your insurance provider and is your responsibility. You may call any of our offices at any time to speak with a representative or to leave a message on our answering machines to notify us of any changes to your previously scheduled appointment. Keep in mind that should your therapist encounter an emergency situation or become ill and your appointment is rescheduled as a result, you will not be assessed a fee.

Additionally, when patients do cancel appointments, we will make every effort to minimize the impact to our therapist's schedules. We may, on occasion, contact patients to see if moving them to another time is convenient for both parties. If you are able to accommodate we sincerely appreciate your flexibility. By the same token, if you find that you have a schedule change that conflicts with your previously scheduled appointment, we encourage you to call as quickly as possible to reschedule. If the required schedule change falls outside of the 24-hour notice period but one that we can easily accommodate you will not be assessed the cancellation fee of \$35.

If we are billing a workers' compensation carrier or motor vehicle insurance provider for an existing claim, you cannot be assessed a cancellation fee for missed appointments. Please be advised that we may elect to discontinue your treatment after three missed appointments for those who do not adhere to our policy.

Your time is precious and we will make every effort to accommodate your schedule. We ask for the same courtesy and will do our best to make sure that we run on time and make your appointment specific to you and your needs.

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
                    First                    MI                    Last

**Date of Birth:** \_\_\_\_\_

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible.

1. Are you currently receiving health care?  Yes  No      If yes, where and from whom? \_\_\_\_\_

\_\_\_\_\_

2. Please identify below the health concerns that have brought you to the clinic:

<u>Condition</u>	<u>Past Treatment</u>
a. _____	_____
b. _____	_____
c. _____	_____

3. Are you pregnant or is there any possibility you could be pregnant?  Yes  No

4. Do you have any chronic infectious diseases?  Yes  No      If yes, please explain: \_\_\_\_\_

5. Are you currently suffering from any chronic illness?  Yes  No      If yes, please explain: \_\_\_\_\_

6. Significant diseases, injuries, accidents, hospitalizations, surgeries, x-rays, CAT scans, MRIs, NMRs, special studies:

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
a. _____	_____	_____	_____
b. _____	_____	_____	_____
c. _____	_____	_____	_____

7. Please list any prescription medications, over-the-counter medications, or vitamin supplements that you are currently taking and give your dosage: (or provide a list of medications to your provider.)

\_\_\_\_\_  
\_\_\_\_\_

8. Please list any foods, drugs, or medications you are hypersensitive or allergic to (please include the type of reaction):

\_\_\_\_\_  
\_\_\_\_\_







## NOTICE OF PRIVACY PRACTICES

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

This notice describes the procedures and practices that this clinic and its professional, support and administrative staff follow to protect the privacy of your health information.

### YOUR HEALTH INFORMATION:

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office. Your health information may include information created and received by this office, it may be in the form of written or electronic records or spoken words, and it may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

### HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

We may use and disclose health information for the following purposes:

#### **For Treatment**

We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to physicians, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, the physician who referred you for physical therapy may be treating you for a medical or orthopedic condition and we may need to know about that and any other health issues that may complicate your treatment. We may use your medical history to decide what treatment is best for you. We will consult with your doctor and send reports about your treatment to the physician. We do this to provide the most appropriate care for you. Various members of our staff may also share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as telephoning your physician and getting required information. Family members and other health care providers may be part of your physical therapy treatment outside this office which may require us to provide information about you.

#### **For Payment**

We may need to disclose health information about you in order to bill your health plan or insurance company or other third party for your treatment in this clinic.

We may also need to tell your health plan or insurance company about a treatment you may receive in order to obtain prior approval, or to determine whether your plan will cover the treatment.

#### **For Health Care Operations**

We may use and disclose health information about you in order to manage the clinic and ensure that you and our other patients receive quality care.

For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient or whether certain treatments are effective for certain issues.

We may also disclose your health information to your health plan and other health care providers that care for you in order to help these plans and providers evaluate or improve care, reduce cost, coordinate and manage health care and services, train staff and comply with the law.

### **Appointment Reminders**

We may contact you to remind you of your scheduled appointments with our clinic.

### **Treatment Alternatives**

We may tell you about or recommend possible treatment options or alternatives that may interest you.

### **Health-Related Products and Services**

We may tell you about health-related products or services that may interest you.

Please notify us if you do not wish to be contacted with appointment reminders, or if you do not wish to receive communications about treatment alternatives, health-related products and/or services. If you advise us in writing (at the address listed at the top of this notice) that you do not wish to receive these communications, we will not use or disclose your information for these purposes.

### OTHER CIRCUMSTANCES:

We may use or disclose health information about you for the following purposes, in accordance with the requirements and limitations of state and other applicable law:

#### **To Avert a Serious Threat to Health or Safety**

We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

#### **Required by Law**

We will disclose health information about you when required to do so by federal, state or local law.

#### **Research**

We may use and disclose health information about you for research projects that are subject to special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at our clinic.

#### **Military, Veterans, National Security and Intelligence**

If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

#### **Workers' Compensation**

We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

#### **Public Health Risks**

We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report suspected abuse or neglect, non-accidental physical injuries or problems with conduct.

### **Health Oversight Activities**

We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

### **Lawsuits or Disputes**

If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

### **Law Enforcement**

We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

### **Coroners, Medical Examiners and Funeral Directors**

We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death.

### **Information Not Personally Identifiable**

We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

### **Family and Friends**

We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume that you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the room during treatment or while treatment is being discussed. Additionally, in situations where you are not capable of giving consent (due to incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your case.

### **Non-Custodial Parent**

We may disclose health information about a minor child equally to the custodial and non-custodial parent unless a court order limits the non-custodial parent's access to the information.

### **OTHER USES AND DISCLOSURES PURSUANT TO YOUR SIGNED AUTHORIZATION:**

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written authorization. If you sign an authorization for use to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose information about you for the reasons covered by your written authorization, but we cannot take back any uses or disclosures already made with your permission.

### **YOUR RIGHTS REGARDING HEALTH INFORMATION:**

You have the following rights regarding health information we maintain about you.

#### **Right to Inspect and Copy**

You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to the Director of Operations/Human Resources in order to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associate supplies. We may deny your request to inspect and/or copy records in certain limited circumstances. If you

are denied copies of or access to, health information that we keep about you, you may ask that our denial be reviewed. If the law provides you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of said review.

### **Right to Correct**

If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request a correction as long as the information is kept by this office. To request a correction, you must complete a Medical Record Amendment/Correction Form to the Director of Operations/Human Resources. We will provide you with the above at your request.

We may deny your request for an amendment if your request is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to alter information that:

- We did not create, unless the person or entity that created the information is no longer available to make the correction;
- Is not part of the health information that we keep;
- You would not be permitted to inspect and copy; and/or
- Is accurate and complete.

### **Right to Accounting Disclosures**

You have the right to request an “accounting of disclosures”. This is a record of the disclosures we have made of medical information about you for purposes other than treatment, payment, health care operations, and a limited number of special circumstances involving national security, correctional institutions and law enforcement. The record may also exclude any disclosures we have made based on your written authorization.

To obtain this accounting, you must submit your request in writing to the Director of Operations/Human Resources. It must state the time period for which you want accounting. The time period may not be longer than six (6) years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronic copy). The first list you request within a 12-month period will be free. We reserve the right to charge you for any additional list requests. We will notify you of the costs involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

### **Right to Request Restrictions**

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information regarding a particular surgery that you had.

We are not required to comply with your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or we are required by law to disclose the information.

To request restrictions, you must complete and submit the Request for Restriction on Use/Disclosure of Medical Information and/or Confidential Communication to the Director of Operations/Human Resources. We will provide this form upon your request.

### **Right to Request Confidential Communications**

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location or time. For example, you may ask that we only contact you at work or via email.

To request confidential communications, you may complete and submit the Request for Restriction on Use/Disclosure of Medical Information and/or Confidential Communication to the Director of Operations/Human Resources. We will not ask the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.