Today's Date: __________

YPB PATIENT REGISTRATION

Last Name ______________________ First Name ______________________ MI __________

Date of Birth ______________________ Social Security ______________________ Gender M / F

Street Address ____

City ______________________ State ______________ ZIP ______________

Home Phone ______________________ Work Phone ______________ Mobile ______________

Email ____ Work Status ______________

Employer Name ____ Phone ______________

Emergency Contact ____ Phone ______________

Referring Physician ____ Phone ______________

How did you hear about us? ____

Injury related to: ◯ Work ◯ Automobile Accident ◯ Other ______________________

Required information for Workers Compensation, Automobile Accident, or Letter of Attorney:

Claim # ______________________ Adjuster ______________ Phone ______________

Credit Card Information (Optional)

◯ Visa ◯ MC Card # ______________________ Exp Date __________ CVV Code __________

Important Company Policies

Consent To Treat

YPB therapists have patient's consent to treat and are not liable for injuries or harm incurred during or as a result of treatment.

Cancellation Fee

If you wish to cancel or change an appointment, we require a 24 hour advance notice. **No-shows or cancellations within 24-hours will incur a $20 late fee.** We encourage patients to arrive promptly to their appointments in order to receive the maximum benefit of therapy.

Prompt Payment

You are responsible by law for the timely payment of your account. Deductible and copayments **are due at the time of your visit.**

We look forward to building a successful relationship with you that lasts a life time!

Patient Signature ____

Payment Authorization

Insurance Is Your Responsibility

Insurance coverage is a contract between you and your insurance coverage. We are not party to this contract. Insurance claims are filed *as a courtesy* to you. We will not become involved in disputes between you and your insurance carrier other than to supply factual information as necessary. You are responsible for keeping us informed of any changes to your demographics or insurance policy as well as prompt payment of your account.

IMPORTANT - *We call on your insurance benefits as a courtesy. Verification of benefits by Your Personal Best is not a guarantee of payment by your insurance company. We strongly encourage our patients to call and confirm their benefits.*

Direct Assignment of Insurance Benefits

I hereby instruct and direct my insurance company to pay by check made out to and mailed to: Your Personal Best Physical Therapy. If my policy prohibits direct payment to my healthcare provider, I will make a check to Your Personal Best Physical Therapy for the professional expense benefits allowed, and otherwise payable to me under my current insurance policy, as payment toward the total charges for the professional services rendered. I authorize *Your Personal Best Physical Therapy* to deposit checks made in my name.

Prompt Payment & Collections

I understand I am responsible by law for the timely payment of my account. If I fail to pay my balance in a timely manner, I am aware my account will be sent to collections, where it may accumulate interest.

Patient Signature ______________________________________

. . . .

Contact Authorization

I give permission to *Your Personal Best Physical Therapy* to contact me by phone or e-mail with appointment reminders, including leaving messages at home or work. I also give permission to *Your Personal Best Physical Therapy* to contact me by phone, mail, or e-mail for purposes including, but not limited to, YPB newsletters and promotional mailings, birthday or holiday-related cards, and thank-yous for patient referrals.

I (**DO / DO NOT**) consent and agree that Your Personal Best Physical Therapy has the right to take photographs or record video of me (and/or my property) to use in any and all media, now or hereafter known, for any YPB marketing purposes whatsoever. I understand that Your Personal Best Physical Therapy will have all rights to exhibit this work in print and electronic form (video/print/web) publicly or privately and I waive any rights, claims or interest I may have to control the use of my identity or likeness in the photographs and agree that any uses described herein may be made without compensation or additional consideration of me.

Patient Signature ______________________________________

Medical Questionnaire

1. Have you had physical therapy before? ☐ Yes ☐ No Age: ________

2. Where is your injury / pain? ________

3. What caused your injury / pain? ________

4. Approximately when did it begin? Is pain improving, worsening, or same? ________

5. Please rate your level of pain. (Circle below)

   Mild Moderate Severe

   0 . . . 1 . . . 2. . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10

6. Please rate your level of activity restriction. (Circle below)

   Mild Moderate Severe

   0 . . . 1 . . . 2. . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10

7. What is your occupation? ________

8. Have you had surgery? If so, when? ________

9. Are you taking medication? If so, what? Are they helping? ________

10. What are your physical therapy goals? ________

10. Please list any other relevant medical conditions or information. ________

Your Personal Best Physical Therapy
5000 Bee Cave Road, Suite 204, Austin, Texas 78746 Ph. 512-329-6617
11614 BeeCave Road, Suite 160, Austin, Texas Ph. 512-428-4261

Statement of Privacy Notice

We may disclose your health care information as necessary in situations listed below.

- Other health care professionals within our practice for the purpose of treatment, payment, or health care operations.
- Insurance provider for the purpose of payment or health care operations.
- Public health authorities for purposes relating 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.
- Law enforcement officials 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.
- Coroners or medical examiners.
- Organizations involved in procuring, banking, or transplanting organs and tissues.
- Researchers conducting research that has been approved by an Institutional Review Board.
- Appropriate persons in order to prevent or lesson a serious and imminent threat to the health or safety of a particular person or to the general public.
- Appropriate persons in order to comply with State Workers Compensation Laws; administrative or judicial proceedings; and military, national security, and government purposes.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

As the patient, you have the right to:

- Request restrictions on certain uses and disclosures of your health information. Please be advised that we are not required to agree to the restriction requested.
- Have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication delivery, upon your request.
- Inspect and copy your health information.
- Request that we amend your protected health information. If your request is denied, you will be provided with an explanation of our denial reasons and information on how you can disagree with the denial.
- Receive an accounting of disclosures of your protected health information made by us.
- A paper copy of this Notice of Privacy Practices at any time upon request.

We have the right to amend this Notice of 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, please call our office at 512-329-6617.

I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide *Your Personal Best* with my authorization and consent to use and disclose my protected healthcare information for the purposes of treatment, payment and healthcare operations as described in the Privacy Notice.

Patient's Signature ____