Patient Registration

PLEASE PRINT CLEARLY

FOCUS PHYSICAL THERAPY
Hands-on care from start to finish

30212 Tomas, Suite 120
Rancho Santa Margarita, CA 92688
Ph: 949-709-8770 Fax: 949-709-4064

Personal Information

Date _____Name _____
First MI Last

Address_____

City_____ State _____ Zip _____

Home Phone _____ Work Phone_____ Cell _____

Date of Birth _____ Social Security #_____ M / F Marital Status: M S D W O

Parent/Guardian Name: _____ Date of Birth_____ Phone _____

Email Address: _____ Social Media: ___ Facebook ___ Twitter

Please send appointment reminders to my: E-mail _____ Phone Call _____ Text _____ (Cell Phone Carrier: _____)
Cancellation policy still applies even if you failed to receive your appointment reminder, appt. schedules can be printed upon request.

Employed YES NO Employer_____ Phone _____ Position_____

Emergency Contact: Name _____Relationship _____ Phone_____

Referred to Focus Physical Therapy by? ___PHYSICIAN ___FAMILY/FRIEND ___ INSURANCE ___ OTHER_____

Who can we thank for sending you to Focus?_____

Is this a Workers Compensation Claim? Yes ___ No ___ Date of Injury _____ Company where injured? _____

Is this an Accident Case? Yes ____ No ____ Vehicle Yes____ No ____ Auto Insurance Company _____

If Medicare, are you receiving ANY form of Home Health Care at this time? _____

Consent to Treat: I understand that by signing I am giving my permission for evaluation and treatment by **Focus Physical Therapy** and that I have the right to refuse any procedure after having the risks and benefits explained to me.

Cancellation Policy: I understand that I am to give FOCUS PHYSICAL THERAPY 24 hours notice of any cancellations.
There is an answering machine for my convenience which is available to me at any time. Excessive cancellations/no shows will lead to cancellation of all future scheduled appointments & notification to my physician or adjuster.
I understand that I am subject to a cancellation fee of $50.00 for each same day cancellation or no show appointment.

HIPAA Policy: I acknowledge that **Hands On Physical Therapy Inc./Focus Physical Therapy** has supplied me with a copy of their Office Policies and Health Information Privacy Practice Agreement (HIPAA) regarding their policies and procedures concerning my Protected Health Information (PHI). I agree to release authorization to Hands On Physical Therapy or Focus Physical Therapy to use my PHI as deemed necessary for treatment, billing and the purposes mentioned in the notice.

Payment Policy: Co-pay/Co-Insurance and Deductibles not met are due at time service is rendered. If you cannot settle your account at the time of each visit, special arrangements must be made in advance with our office.

I would like to keep a credit card on file, to be charged weekly, for any co-pays or coinsurance owed by me. **(We accept Visa, Master-Card or Debit Cards)**

Please see Insurance Verification/Financial Agreement for your benefit detail.

PLEASE CHARGE WEEKLY my co-pay or coinsurance to my _____Card # _____

Name on Card: _____ Expiration Date _____ Security Code _____

The above information is correct to the best of my knowledge. I have read, understand and agree to this statement in its entirety.

Signature: _____ Date _____

Signature of responsible party if minor (under 18 years of age): _____