Welcome! Thank you for allowing Fukuji & Lum PT to serve as your provider for physical therapy care. We appreciate the trust you and your physician have placed in us. If you have any questions or need any assistance please ask the receptionist. Thank you!

Location:_____

FUKUJI & LUM
PHYSICAL THERAPY ASSOCIATES

Confidential Patient Information

Name: (Last)_____ (First)_____ (M.I.)_____ Sex: ○M ○F

Preferred Name:_____ E-mail address:_____

Birth Date:_____ SS#_____-_____-_____ Phone: Home_____ Cell_____

Address: _____
City State Zip Code

Emergency Contact Name:_____ Relationship: _____ Phone:_____

How did you hear about our clinic and services?

☐ Internet Search ☐ Facebook ☐ Instagram ☐ Website ☐ Advertisement / Flyer ☐ API

☐ Event:_____ ☐ Other: _____

Were you referred to us by someone? ☐ Doctor ☐ Fukuji & Lum employee: _____

☐ Friend / Relative - Was he/she a former patient? ☐ No ☐ Yes, Name: _____

Insurance Information

Primary Insurance Company: _____

Name of insured: (Last)_____ (First)_____ (M.I.)_____ Sex: ○M ○F

Birth Date:_____ Relationship to insured: ☐Self ☐Spouse ☐Child ☐Other:_____

Secondary Insurance Company: _____

Name of insured: (Last)_____ (First)_____ (M.I.)_____ Sex: ○M ○F

Birth Date:_____ Relationship to insured: ☐Self ☐Spouse ☐Child ☐Other:_____

Additional Patient Information:

Occupation:_____

Employer:_____ Work Phone:_____

Employer's Address:_____
City State Zip Code

ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION TO INSURANCE COMPANY

I hereby authorize Fukuji & Lum Physical Therapy Associates, Inc. or its representative, Team Praxis to release to my insurance company or its representative my information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical care.

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare, Tricare, Private Ins., and any other health plan to Fukuji & Lum Physical Therapy Associates, Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event of default, I (we) promise to pay legal interest on the indebtedness, together with collection costs (plus $20.00 processing fee) and reasonable attorney fees as may be required to affect collection of this note. I hereby authorize said assignee to release all information necessary to secure payment.

Signature: _____ **Date:** _____

Patient Attendance Policy Agreement:

A consistent treatment schedule is vital to the success in your physical therapy progress. Not adhering to the schedule set by you and your therapist could hinder the achievement of desired outcomes.

At Fukuji & Lum Physical Therapy, we strive to provide you with the highest quality of care while attempting to accommodate your schedule. Cancellations, especially last minute ones, along with patient no-shows, decrease our ability to accommodate the scheduling needs of other patients. Therefore, we must ask for your full cooperation with the following policy:

- If you are unable to keep an appointment, we request that you notify our office 24 hours in advance of your scheduled appointment time. If someone is not available to take your call, please leave a message on our answering system.
- If you no show for two consecutive appointments without notifying us, we may cancel any future appointments you have, you may be referred back to your Physician, or your therapist may choose to discharge you.
- All cancellations and no-shows will be documented in our medical records and in certain situations such as workers' compensation cases, we are required to report treatment compliance to your adjuster/nurse case manager.

  We recommend that you make up a missed appointment within the same week in order to comply with the treatment plan approved by your physician.

I have read, understand and agree to the Patient Attendance Policy. (Please Initial) _____

Cost of Treatment:

The cost of your treatment may be covered in whole or in part by your insurance company. You are responsible for payment of any deductibles, co-pays or denied claims. **Please call your insurance company for your individual physical therapy benefits.**

Cash, check, or credit card may be used for payment. There is a $25.00 fee for returned checks.

I have read, understand and agree to the Cost of Treatment Policy. (Please Initial) _____

***Consent to Disclose Health Information* & Acknowledgement of Receipt of Notice of Privacy Practices:**

Please read our Notice of Privacy Practices as it provides a description of our treatment, payment activities, and healthcare operations as it outlines the use and limitations of the disclosure of your health information and your rights as a patient. We reserve the right to change our privacy practices in accordance with the law. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting any of our offices or by visiting our website (go to: Your 1st Visit, then Download Forms).

Please verify that you have been given a copy of our Notice by initialing here: _____

I authorize Fukuji & Lum Physical Therapy Associates, Inc. to use and disclose my (or my child's) health and medical information for the purpose of Treatment, Payment, and Healthcare Operations.

I understand that I have the right to revoke this consent provided that I do so **in writing**, except to the extent that Fukuji & Lum Physical Therapy Associates, Inc. has already used or disclosed the information reliance on this consent.

Signature: _____ **Date:** _____

YOU ARE ENTITLED TO A COPY OF THIS FORM AFTER YOU SIGN IT.