Registration Form

FABIAN
PHYSICAL THERAPY LLC
Erika Fabian PT, FCAMPT
95 Lono Avenue, Suite 202
Kahului, Maui, Hawai'i 96732
Tel 808.872.3333 Fax 808.872.3332
Email erika@fabianpt.com

Name:_____ Birthdate:___/___/___

Address:_____City & Zip:_____

Home phone: _____ Cell Phone: _____Work phone:_____

E-mail:_____

Occupation:_____Employer:_____

Referring Doctor:_____Phone/Fax:_____

In case of Emergency, please indicate below whom we should call:

Name:_____Phone:_____

Relationship:_____Alternate phone number:_____

Cooperation with treatment:
I understand that in order for physical therapy treatments to be effective, I must come to scheduled appointments unless there are unusual circumstances that prevent me from attending therapy. I understand and agree to cooperate with and perform the home physical therapy program prescribed for me. If I have any problems with my treatment program I will discuss it with my therapist. I understand that the physical therapists can not make any promises or guarantees regarding a cure for, or improvement in my condition. I understand that my therapist will discuss treatment options with me before I consent to treatment.

Consent to treatment at Fabian Physical Therapy LLC:
I wish to receive physical therapy treatment(s) with Fabian Physical Therapy LLC. Accordingly, I authorize an give full consent for services rendered to me under the general and specific instruction of my attending therapist as may be determined by her professional judgement. I understand that I will receive information at the initial visit concerning the treatment and options available for my condition. Treatment may consist of, but not limited to: hot/cold packs, manual therapy, therapeutic exercises, ultrasound, electrical stimulation and other modalities/techniques that the therapist may deem beneficial to recovery. As with any medical treatment side effects may occur. Soreness of muscle/joint, muscle spasm as well as bruising might occur and is usually resolved with the first 24 hours. Care should be take when driving immediately after treatment.

By signing below, I indicate that I am aware of and accept the conditions as well as the risks of my treatment. I have the right to decline any part of the treatment at any time and in doing so, I am aware, that the effectiveness of the treatment might decrease.

All physical therapy treatment options available to my conditions, potential risks, benefits and alternatives to physical therapy treatment have been explained to me. I have asked any questions and they have been answered to my satisfaction. I understand the risks and benefits and alternatives to treatment.
I hereby authorize Erika Fabian to examine and treat my condition as she deems appropriate through the use of Physical Therapy and I give authority for these procedures to be performed.

Financial agreement and payment provisions:
I agree to pay for my treatments at time of service. I understand that it is my responsibility to call my insurance company ahead of time, and obtain any pre-authorization that is necessary, and get an estimate of benefits. I understand that my therapist will provide me with a receipt and, that is my responsibility to submit to my insurance company.
Should the account be referred to an attorney, collection bureau or other entity for non-payment; I understand that I will also be responsible for expenses incurred, to include, but not limited to, court fees, collection fees, attorney fees etc. Any returned non-sufficient funds checks will incur a 20.00 fee in addition to payment amount.

Cancellation/late/no show policy:
I understand if I don't show up twice for a scheduled appointment I will be fully charged for a visit. I further understand that if I am late for my appointment my treatment time will be cut and if I am more than 15 minutes late I might be asked to reschedule to a later date or time. Missed appointment will be documented in my medical file. My signature below certifies that I have read, fully understand and accept the above terms/policies and will comply with said terms. By signing below, I am stating that I am the guarantor.

_____

Signature Date

_____

Printed name Birthdate

_____

Guardian signature Therapist signature/Date

Notice of Privacy Practices Patient Acknowledgement

PLEASE FILL OUT AND BRING WITH YOU TO YOUR FIRST APPOINTMENT

Patient Name:_____

Date of Birth: ____/____/____

I have received this practice's Notice of Privacy Practices (HIPPA) written in plain language, The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy on request.

Signature: _____

Date:_____

Relationship to patient (if signed by a personal representative of patient):

_____