Physical Therapy Solutions

Patient Registration Form

PATIENT INFORMATION

Patient's Name_____
Last First Middle

Patient's Address_____
Street City State Zip+4

Primary Contact Number/Type: _____

Status: □ Married □ Single □ Full Time Student □ Part Time Student □ Employed □ Other

Social Security Number: _____Birthdate:_____

Patient's/Sponsor's Employer: _____Work#_____

Employer Address: _____
Street City, State, Zip code

CASE / VISIT INFORMATION VERY IMPORTANT

How did you hear about us? _____

Please note reason for your visit today:

_____

_____

Referring Physician: _____Primary Care Physician: _____

Please check (√) any of the following whose care you are under:

____Orthopedist ____Psychiatrist/Psychologist ____Physical Therapist ____Primary Care Physician
____Neurologist ____Chiropractor ____Home Health ____Neurosurgeon

If you have seen any of the above during the past three months, please describe for what reason. (i.e., illness, medical condition, diagnostic tests, surgery, physical, etc.)

_____
_____

Injury Info: (Work/MVA/Other): **Date:** _____**Time**:_____**Place**:_____

Dates Unable to Work (MMDDYY) Dates of Hospitalization (MMDDYY)
____/____/____- ____/____/____ ____/____/____ - ____/____/____

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Name: _____ Date: _____

Occupation, including activities that comprise your workday: _____

Age: Height: Weight: BMI: R / L Handed? (Circle please)

Have you fallen in the past year? Yes No If so, how many times? _____ Injury sustained _____

Are you on work restrictions from your doctor? Yes No Details: _____

Are you latex sensitive? Yes No Do you smoke? Yes No Do you have a pacemaker? Yes No

FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No

ALLERGIES: List any medication(s) you are allergic to: _____

Have you RECENTLY noted any of the following (check all that apply)?

❑ Fatigue	❑ Numbness or tingling	❑ Constipation
❑ Fever/chills/sweats	❑ Muscle weakness	❑ Diarrhea
❑ Nausea/vomiting	❑ Dizziness/lightheadedness	❑ Shortness of breath
❑ Weight loss/gain	❑ Heartburn/indigestion	❑ Fainting
❑ Balance issues	❑ Difficulty swallowing	❑ Cough
❑ Falls	❑ Changes in bowel/bladder function	❑ Headaches

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

❑ Cancer Type_____	❑ Depression	❑ Thyroid problems
❑ Cardiovascular disease	❑ COPD	❑ Diabetes
❑ Chest pain/angina	❑ Emphysema	❑ Osteoporosis
❑ High blood pressure	❑ Asthma	❑ Multiple sclerosis
❑ High cholesterol	❑ Rheumatoid arthritis	❑ Epilepsy
❑ Blood clots	❑ Osteoarthritis	❑ Eye problems
❑ Stroke	❑ Bladder/UTI	❑ Ulcers
❑ Anemia	❑ Kidney problem/infection	❑ GERD
❑ Bone or joint infection	❑ Sexually transmitted disease/HIV	❑ Hepatitis
❑ Chemical dependency (i.e., alcoholism)	❑ Pelvic inflammatory disease	❑ Pneumonia

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

❑ Cancer Type_____	❑ Diabetes	❑ Osteoporosis
❑ Cardiovascular disease	❑ Stroke	❑ Thyroid problems
❑ High blood pressure	❑ Depression	❑ Blood clots

During the past month have you been feeling down, depressed or hopeless? **YES NO**
During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**
Is this something with which you would like help? **YES YES, BUT NOT TODAY NO**
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? **YES NO**

Please list your surgery history including dates:

1. _____ 2._____ 3._____

4._____ 5._____ 6._____

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Please list ALL prescription medications, over-the-counter medications, dietary/nutritional supplements (vitamins, minerals, herbal). Please include Name, Dosage, Frequency, and Route of Administration.

NAME	DOSAGE	FREQUENCY	ROUTE OF ADMINISTRATION
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

Have you ever taken steroid medications for any medical condition? **YES** **NO**

Have you ever taken blood thinning or anticoagulant medications for any medical condition? **YES** **NO**

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CURRENT CONDITION PROFILE

What date did your present symptoms start? _____

What do you think caused your symptoms? _____

My symptoms are currently: ❑ **Getting Better** ❑ **Getting Worse** ❑ **Staying about the same**

Treatment received so far for this problem (PT, OT, chiropractic, injections, etc):
_____

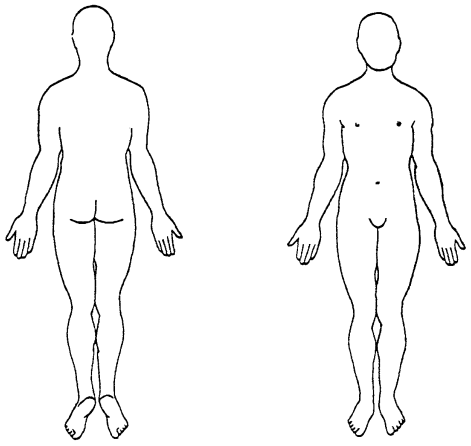
Please list special tests performed for this problem (X-Ray, MRI, CT, EMG, etc) _____

Have you ever had this problem before: ❑ **Yes** ❑ **No** **When**_____ **Treatment rec'd**_____

Body Chart:

Please mark the areas where you feel symptoms using the symbols below to describe your symptoms:

↓ **Shooting/Radiating/Sharp Pain**
O **Dull/Aching pain**
||| **Numbness**
= **Tingling**



My symptoms currently: ❑ Come and go ❑ Are Constant ❑ Are constant, but change with activity

Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:
1. _____
2. _____
3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:
1. _____
2. _____
3. _____

How are you currently able to sleep at night due to your symptoms?
❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

When are your symptoms worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise
When are your symptoms the best? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

Using a Numeric Rating Scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:
Your current level of pain while completing this survey: _____
The best your pain has been during the past 7 days: _____
The worst your pain has been during the past 7 days: _____

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FINANCIAL AGREEMENT/CONSENT FORM

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to **Physical Therapy Solutions** of the benefits otherwise payable to me for services rendered.

PRECERTIFICATION POLICY

I understand that Physical Therapy Solutions will assist with insurance precertification requirements, which are the responsibility of the policy holder and/or physician, but will not assume responsibility for precertification or any impact which it may have on insurance payment.

IF MY INSURANCE PAYS ME DIRECTLY

If my insurance or other source reimburses me directly, I will immediately endorse their check over to **Physical Therapy Solutions** or submit payment with my own personal check.

DEDUCTIBLES ● CO-PAYMENTS ● BALANCE DUE

Co-payments and co-insurance are to be paid **AT TIME OF SERVICE** unless prior arrangements have been made with the Office Manager, Francine Stone. Statements will be sent after remit from your insurance has been posted.
Balance is due upon receipt of statement. Patients are to keep payments current.
Please call Francine if you are unsure of your benefits, network status, co-insurance or co-pay.

LEGAL FEES

I agree that should it become necessary for my account to be referred to an attorney or agency for collection or suit, I will pay all attorney fees, court costs and collection costs.

SUPPLIES●EQUIPMENT

All supplies/equipment given to a patient shall be paid for by the patient upon receipt, **unless this is an accepted Workers' Compensation case in which the insurance will pay.**

CONSENT FOR TREATMENT

I, the undersigned, a patient at Physical Therapy Solutions do hereby authorize Anne McClure, PT, DPT and whomever she may designate as her assistant(s) to administer treatment as is deemed necessary and/or advisable. I have the right to consent or refuse consent, to any proposed physical therapy course of treatment.

BY SIGNING BELOW, I AGREE TO ALL TERMS AND CONDITIONS STATED ABOVE.

_____ _____
Signature of Patient or Legal Guardian **Date**

_____ _____
Signature of Responsible Party **Date**

_____
Printed Name

5/9

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PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Phone(s) _____

☐ O.K. to leave message with detailed information

☐ Leave message with call back number only

☐ Written Communication

☐ O.K. to mail to my home address

☐ O.K. to mail to my work/office address

☐ O.K. to fax to this number _____

Whom may we share your PHI with or request your PHI from?

NAME RELATIONSHIP or FACILITY

_____

_____

_____

_____ _____

Patient / Guardian Signature Date

_____

Print Name Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, if complet properly, will constitute an adequate record.

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key: T = Treatment Records: P = Payment Information: O = Healthcare Operations
(3) Enter how disclosure was made: F = Fax; P = Phone; E = Email; M = Mail; O = Other

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NOTICE FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically this record contains your health history, current symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatments. This information is referred to as your health or medical records and serves as the following:

- A basis of planning your care and treatment
- A means of communication among health professionals involved in your care
- A legal document describing the care you received
- A means by which you or a third-party payer can certify that services billed were actually provided
- A tool to assess the quality of care you received and goals achieved

You have the following rights regarding PHI we maintain about you:

- Right to inspect and obtain a copy of your health record
- Right to request a restriction on certain uses and disclosures of your information
- Right to request an amendment to your health record
- Right to request an accounting of disclosures of your health information
- Right to request confidential communications of your health information by alternative means, such as by mail, or at alternative locations, such as at work

Physical Therapy Solutions may use and disclose your PHI for the following reasons:

- Treatment – We may use PHI to determine the best course of treatment for you. Observations, treatments and results in physical therapy will be documented in your record, and this information may be provided to your physicians and other providers involved in your care.
- Payment - We may use PHI in order to bill for services received and collect payment from you, an insurance company or a third party.
- Appointment Reminders - We may use and disclose PHI to contact you as a reminder that you have a physical therapy appointment. If you are not at home, we may leave this information on your answering machine or in a message left with the person answering the telephone.
- Individuals Involved in Your Care or Payment for Your Care – We may release PHI to a friend or family member who is involved in your medical care or someone who helps pay for your care.
- As Required by Law – We may disclose PHI when required to do so by federal, state or local law.
- Workers' Compensation – We may release PHI for workers' compensation or similar programs as authorized by state laws.
- Lawsuits and Disputes – We may disclose PHI in response to a court or administrative order if you are involved in a lawsuit or dispute.
- Law Enforcement – We may release PHI if asked to do so by a law enforcement official in response to a court order, warrant, or summons or criminal investigation.

We reserve the right to change this notice. We reserve the right to make the revised notice effective for PHI we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility.

I have read and understand the above disclosure. I authorize Physical Therapy Solutions to use my PHI as set out above. I understand that a copy of this disclosure is available to me at my request.

Patient Signature_____Date:_____

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No Show/Cancellation Policy

Consistent attendance in physical therapy is essential to good outcomes and cancellation/no shows are highly discouraged. Please arrive for your appointment on time. If you are more than 15 minutes late for your appointment, you may be asked to wait until your therapist is available or more likely, to reschedule your appointment and have a cancellation recorded for that day. All cancellations and no show appointments will be recorded in your chart.

When you miss 3 appointments due to a no show or cancellation, your reserved appointments will be removed from our schedule. This will allow us to utilize that appointment time for another patient. You will need to call to schedule future appointments. In the event that you must cancel an appointment, we would greatly appreciate a 24 hour notice.

We appreciate your cooperation in assisting us help you and others.

Initials_____

Date_____

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INSURANCE INFORMATION

The majority of insurance companies have a co-pay or co-insurance. If you are unsure of your benefits please ask. Thank you!

PRIMARY INSURANCE SUBSCRIBER INFORMATION

Insurance Company: _____

Subscriber's/Insured's Name: _____

Policy / I.D#:_____Group#:_____

Date of Birth: _____SS#:_____

Subscriber's Employer _____Tel#_____

Employer's Address: _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____

Subscriber's/ Insured's Name: _____

Policy / I.D. #:_____Group#:_____

Date of Birth: _____SS#:_____

Subscriber's Employer: _____Tel#_____

Employer's Address: _____

IS THERE A THIRD INSURANCE? ____YES/NO____

We do not file third insurance.