Patient Registration

PLEASE PRINT

LAST NAME ______________________________**FIRST NAME**____________________________

ADDRESS____

CITY ______________________________________**STATE** ______________**ZIP** ______________

HOME PHONE ______-______-___________**WORK/CELL PHONE** ______-______-____________

E-MAIL ADDRESS: ____

DATE OF BIRTH _______-_______-_______ **AGE** _____________________

SOCIAL SECURITY # _______-_______-________ **SEX** ______________________

SPOUSE' NAME ________________________ **SOCIAL SECURITY #** _______-_______-________

EMPLOYER NAME ____________________________ **PHONE** ____________________________

(LIST SPOUSE INFO IF NOT CURRENTLY WORKING)

ADDRESS ____

EMERGENCY CONTACT _______________________________**PHONE** _____-_____-__________

RELATION ____

REFERRED BY: _____________________________________**PHONE** _____-_____-__________

PRIMARY CARE PHYSICIAN: ____________________________ **Date of Injury** ____-____-____
(If applicable)

FORM OF PAYMENT: (*Circle one*)**PRIVATE INSURANCE** **WORK COMP** **SELF PAY** **AUTO**

If Work Comp, Employer at time of injury ____________________Phone _____-_____-__________

IS THERE A SECONDARY INSURANCE? ____

WHO WILL BE RESPONSIBLE FOR THE BILL? _______________________________________

I WILL BE PAYING MY SHARE OF THE FINANCIAL RESPONSIBILITY BY:

CASH _________________ **CHECK** ________________ **CREDIT CARD** ______________

* *

ASSIGNMENT OF BENEFITS

I understand that payment for service is expected at the time service is rendered unless my insurance is to be billed. I understand that I am financially responsible for all charges whether or not they are paid by my insurance. I hereby authorize Physical Therapy Specialties to release all information necessary to secure the payment of benefits. I authorize my insurance benefits to be paid directly to Physical Therapy Specialties.

SIGNATURE _____________________________________**DATE** __________________________

* 12/10

PHYSICAL THERAPY SPECIALTIES

Health History

12/10

1. Do you have any of the following Medical Conditions? ***Please circle Yes/No***

GENERAL MEDICAL CONDITIONS:

Arthritis	Yes	No	Allergies(type)________________________		
Anxiety/Panic Disorders	Yes	No	Back Pain(neck pain, low back pain, degenerative disc disease, spinal stenosis)	Yes	No
Cancer	Yes	No			
Depression	Yes	No	Gastrointestinal Disease(ulcer, hernia, reflux, bowel, liver, gall gall bladder)	Yes	No
Headaches	Yes	No			
Hepatitis/AIDS	Yes	No	Hearing impairment(very hard of hearing, even with hearing aids)	Yes	No
Incontinence	Yes	No			
Osteoporosis	Yes	No	Kidney, bladder, prostate, or urination problems		
Previous accidents	Yes	No	Prosthesis/Implants	Yes	No
Sleep Dysfunction	Yes	No	Neurological Disease (such as MS or Parkinson's)	Yes	No
Numbness/tingling in arms/legs	Yes	No	Visual Impairment(such as cataracts, glaucoma, macular degeneration)	Yes	No

Prior Surgery(s)____

Falls within the past year?____

Infection, please describe ____

Recent fractures (broken bones) if so please list ____

Serious injury, explain ____

Allergies to medication, if so please list ____

Major surgery, type ____

Currently pregnant, if so how many weeks ____

List any other history or medical conditions or illnesses ____

____

____

HEART DISEASE

Angina	Yes	No	Angioplasty	Yes	No
Arrhythmia	Yes	No	Atherosclerotic Disease (Myocardial infarction)(MI)	Yes	No
Congestive Heart Failure(CHF)	Yes	No	Coronary Artery Bypass Graft (CABG)	Yes	No
Heart attack	Yes	No	Heart Problem/Pacemaker	Yes	No
High Blood Pressure	Yes	No	Stents	Yes	No
Valvular Disease	Yes	No			

LUNG DISEASE

Asthma	Yes	No	Chronic Obstructive Pulmonary Disease(COPD)	Yes	No
Emphysema	Yes	No	Recent pneumonia	Yes	No

VASCULAR DISEASE

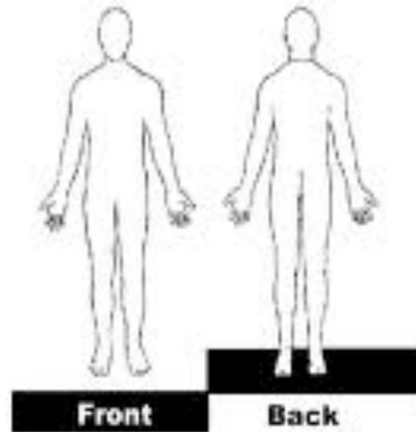
Diabetes	Yes	No	Acquired Respiratory Distress Syndrome (ARDS)	Yes	No
Chronic Bronchitis	Yes	No	Hypertension	Yes	No
Peripheral Arterial Disease	Yes	No	Stroke/TIA	Yes	No
Taking blood pressure medication	Yes	No			

PHYSICAL THERAPY SPECIALTIES

12/10

Health History - PAGE 2

1. Please indicate on the diagram below the location of your pain and describe the type of pain (sharp, dull, aching, shooting, etc.)



2. How did the injury occur?____

____

3. Please rate your pain below by choosing a number from the Pain Scale which represents your pain at its lowest, average and highest.
PAIN SCALE 0-no pain. 1-2-Mild, aware of the pain only when attention is brought to the area. 3-4-Discomforting pain, which may be ignored. 5-Discomforting pain which may be distracting. 6-Distressing pain, but able to perform most tasks. 7-8-Intolerable pain, concentration is difficult, able to perform some tasks. 9-10-Intolerable pain and hospital care is required.

0 1 2 3 4 5 6 7 8 9 10

4. Is your pain increasing? _____ decreasing? _____ same? _____

6. Have you already received treatment for this problem at other locations? (Please circle)
With a:

Medical Doctor	yes	no	Chiropractor	yes	no
Physical Therapist	yes	no	Dentist	yes	no
Psychologist	yes	no	Other ____________________________		

7. What test(s) or treatment(s) have you had concerning this problem? Please check

_____	X-Ray	_____	Myelogram
_____	CT Scan	_____	Cortisone Injections
_____	MRI	_____	Biofeedback
_____	EMG	_____	Other, please explain ________________________________

8. Have you had a similar problem in the past? yes no

9. Are you currently working? yes no

If no, last day worked: ______________

10. Is there anything else you would like to tell us? ________________________________

____

PHYSICAL THERAPY SPECIALTIES

Health History (*TMJ*)

12/10

Name: ______________________________ Date: ______________________

DENTAL BACKGROUND

11. Do you have a regular dentist? yes no
    If so, do they know you are being seen here? yes no

    Dentist's Name ______________________________ Telephone_++++____________________

12. How much dental work have you had? ___ Extensive _______ Routine _______ Minimal

13. Would you say your mouth is: ___ Healthy ____ Average ___ Has many problems

14. Is your bite comfortable? yes no

15. Please check all of the following types of dental care you may have received:

_____ Endodontics (Root canal)
_____ Orthodontics
_____ Oral Surgery
_____ Dental Implants
_____ Periodontics (Treatment of gums)
_____ Extensive Bit Adjustment
_____ Dentures or Partials

16. Please check any of the symptoms that you are experiencing. Your therapist will go over them with you.

_____ Difficulty opening / closing mouth or eating
_____ Headache
_____ Jaw pain
_____ Neck pain
_____ Jaw joint clicking
_____ Jaw joint locking
_____ Tooth pain
_____ Facial pain
_____ Ear pain
_____ Ear buzzing or ringing
_____ Lower back pain
_____ Other (Specify) ____________________________
_____ Eye pain
_____ Blurred vision
_____ Sinus pain
_____ Frequent runny nose
_____ Scalp pain
_____ Clench or grind teeth
_____ Dizziness
_____ Changes in hearing
_____ Upper back pain / Chest pain
____ Arm pain / Numbness

Medication Record

12/10

Patient Name:

Doctor's Name: Telephone Number

In an Emergency Contact: Telephone Number:

Current medications I am taking:

Name of Medication	Strength	Dosage

CONSENT FORM

The following is a list of modalities and procedures used in physical therapy. Your physical therapist will explain which ones will be used during your treatment, discuss treatment alternatives, and goals of treatment with you.

Evaluation
Heat
Ice
Electrical Stimulation
Massage and Muscle Release Techniques
Postural Training
Functional Training
(Body mechanics, Activities of Daily Living)
Ultrasound
Joint Mobilization
Joint Manipulation
Muscle Stretching
Traction
Therapeutic Exercise
Iontophoresis
Biofeedback Training

During your physical therapy it is often necessary to expose or touch the area to be treated. Every effort is made to preserve modesty and keep you comfortable. Our office employs both male and female therapists. Please communicate with our office staff if the gender of your therapist is important to you.

Comments: ____

____

Consent For Treatment

I give my consent for treatment by the health care professional staff of Physical Therapy Specialties to provide physical therapy and rehabilitation services and necessary treatment as prescribed by my physician. I understand that to evaluate and treat my condition, the physical therapy staff must have visual or physical access to the areas of my body which may be experiencing and/or causing my pain and or dysfunction. I understand that it is my responsibility to immediately communicate any difficulties or concerns that I have regarding my therapy to the staff of Physical Therapy Specialties. I further understand that my physician shall be kept informed regarding my current health status and my response to any treatment received. As with any course of treatment or therapy, there is always the possibility of an unexpected complication and no guarantee or assurance has been made as to the results of treatment.

Patient Signature ________________________________ Date____________________

Therapist Signature ______________________________ Date ____________________

CREDIT POLICY

Our credit policy has four options. Please check one of the following:

_____ Option 1: You may **self pay** (cash, check or credit card) for each visit which entitles you to a discount. It is customary to pay for services when rendered, unless other arrangements have been made in advance. Please be prepared to pay for each visit at the time of service.

_____ Option 2: **Work related injury**. Worker's compensation insurance will be billed. No payment is collected from you. Services for industrial injuries must have prior authorization by the industrial carrier. You will be informed if any difficulties in obtaining authorization are encountered. The patient is responsible for all fees should the industrial insurance company deny authorization for treatment.

_____ Option 3: **Private Insurance**:
If your bill is to be paid by a third party, for example an insurance company, it is required that you sign an Assignment of Benefits (See Patient Registration) so that the insurance company can pay us directly. It will be your responsibility to pay the portion of your bill not covered by your insurance company at the time of service (example: deductible, co-payment, share of cost, 20%, etc.). The patient is ultimately responsible for all fees regardless of insurance coverage. We will make every effort to provide only those services considered medically necessary by your insurance plan, unless your express permission is given in writing. Should your insurance plan deem that services are not medically necessary, you will be responsible for the charges.

_____ Option 4: **Auto Accident**:
If you are injured in an auto accident, we will bill your auto insurance carrier if you have MedPay. ***At no time do we accept liens.*** Your auto carrier will not inform us as to the status of remaining funds during your course of treatment. Therefore, we will take an imprint of a credit card to keep on file in case you go over your benefit limit. ***It is your responsibility to track MedPay dollars used*** as your carrier will not supply us with that information. No charges will be billed to your credit card without prior notification from us. A detailed statement will be available for review.

I understand that it is my responsibility to follow the guidelines and to know the coverages and benefits of my medical insurance plan. If I am a member of a managed care program, it is my responsibility to notify Physical Therapy Specialties that my plan requires referrals and to obtain all referrals in advance of services rendered. I understand that I am financially responsible for all services for which I have not obtained a valid referral. I further agree that a photocopy of this agreement shall be as valid as the original.

Note: **24 hour notice is required to cancel an appointment. If notice is not given you may be subject to a late cancellation charge of $25.00. You will be charged the $25.00 fee if you fail (or "no show") to keep your appointment.**

I have read the above, understand it and agree to it.

______________________________ ______________________________
Signature Date 12/10

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Physical Therapy Specialties reserves the right to modify the privacy practices outlined in the notice.

______________________________________ _______________________
Signature Date

____
Print Name

______________________________________ _______________________
Signature of Patient Representative Date
(Required if the patient is a minor or an adult
who is unable to sign this form)

____
Relationship of Patient Representative to Patient