

PATIENT REGISTRATION FORM

Patient Name _____

ID # _____

Patient Address _____

Today's Date _____

City, State, Zip _____

Referring MD _____

Home Phone () _____

Was this an auto accident? _____

Work Phone () _____

Date of injury _____

Cell Phone () _____

E-mail _____

SS# or DL# _____

Birthdate ___/___/___ Age ___

Employer Name _____

Gender: M F Student: Y N

Employment Status: Full Part-Time N/A

Marital Status: M S D W

Have you received Home Health Care within the last 3 months?

Yes No

Have you received Physical Therapy or Speech Therapy at ANY other facility THIS calendar year? Yes No

Please fill out if you are not the insurance cardholder:

Subscriber's Name: _____ DOB: ___/___/___

Relationship to Patient: _____ Place of employment _____

If there is someone whom you would like us to release your information to other than your physician, please fill in their name:

_____	_____
Name	Relationship
_____	_____

A copy of the Notice of Privacy Practices was offered to this patient:

_____ Accepted _____ Declined

Consent for Treatment

I hereby agree to have a licensed Physical Therapist perform an evaluation and render appropriate treatment ordered by my physician. I also authorize the release of any information pertinent regarding my case to any insurance company, adjuster, or attorney involved in the case. I direct the insurer to directly pay, without equivocation, Physical Therapy One all benefits due them and guarantee payment for services.

Courtesy Claim Filing

It is the patient's responsibility to guarantee payment for physical therapy services at Physical Therapy One. As a courtesy, Physical Therapy One will file with your primary and/or secondary health insurance ONE TIME ONLY per visit. You will be responsible for any charges that have been denied by your insurance company. We will provide any necessary information to assist in this filing process.

Cancellation Policy

Physical Therapy One requires 24-hour notice for any cancellation. A \$25.00 fee will be charged to your account for non-compliance including not showing for your appointment. More than 3 (three) cancellations/no-shows will result in an automatic discharge.

SIGN HERE _____ DATE _____

Medical History Information Sheet

Name: _____ Date: _____

1. Medications (Please list **or provide list for the receptionist to copy**):

2. Allergies to medications or latex (Please list):

3. Surgical History (Please list **any** surgeries & year they occurred):

4. Fractures (Please list any previous or current fractures & year they occurred):

5. Do you have a pacemaker? Yes No

6. Medical History

a. Please check if you have ever had:

- | | | |
|--|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes/High Sugar | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Low Blood Sugar/hypoglycemia | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Circulation/vascular problems | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Ulcers/stomach problems |
| <input type="checkbox"/> Blood clots/DVT | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Skin diseases |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures/epilepsy | <input type="checkbox"/> Infectious Disease (TB, HIV, hepatitis) |
| <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> Developmental or growth problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Other: _____ |

b. Please check if you have had in the past year:

- | | | |
|---|---|--|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Bowel problems |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Weight loss/gain |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Joint pain or swelling | <input type="checkbox"/> Urinary problems |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Pain at night | <input type="checkbox"/> Fever/chills/sweats |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Dizziness or blackouts | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Hearing problems |
| <input type="checkbox"/> Coordination problems | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Weakness in legs or arms | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Other: _____ |

Patient/Guardian Signature: _____

FINANCIAL AND BILLING POLICY

We will bill your insurance for you, but you should be aware of the following information:

BILLING YOUR INSURANCE: As a service to our patients, our office will bill your insurance carrier. The final responsibility for the entire balance belongs with you, the patient. You will be expected to pay for any charges that are not covered by your insurance, such as supplies, office visits, copays, deductibles or balances left from an insurance payment. Payment will be expected from you after 30 days from the date of billing. It is up to you to contact your insurance carrier regarding any problems or delays you might be experiencing with your claims, although we would be happy to address any questions that you have. We accept MASTER CARD AND VISA PAYMENTS, CASH OR CHECKS. We can also set up payment arrangements.

COURTESY CLAIM FILING

It is the patient's responsibility to guarantee payment for physical therapy services at PHYSICAL THERAPY ONE. As a courtesy, PHYSICAL THERAPY ONE will file with your primary, and or, secondary health insurance ONE TIME ONLY per visit. You will be responsible for any charges that have been denied by your insurance company. We will provide any necessary information to assist in this filing process.

What does "PARTICIPATE WITH INSURANCE" mean?

WE PARTICIPATE WITH select insurance companies. In most cases this means that we accept the amount that the insurance carrier pays as full payment for our services. You remain responsible for copays or deductibles even if we participate with your insurance carrier. We encourage you to contact your insurance carrier to verify your *physical therapy benefits*.

IF WE DO NOT PARTICIPATE WITH your insurance, we will still bill your carrier for you. However you are responsible for the amount not covered by your insurance carrier.

REFERRALS OR AUTHORIZATIONS If your insurance carrier requires a referral or authorization, these usually come from your primary care physician. Please make sure that this is in place BEFORE services are provided. If proper authorization is not obtained, you may be responsible for your entire balance.

LEGAL ACTIONS FOR PERSONAL INJURY if you are involved with legal action for personal injury, we do not accept this as a reason to delay payment for our services. Responsibilities of payment belong to the patient. We are happy to provide your attorney any information they request with a signed release from you and at a fee they will be required to pay for such records.

Please sign and date below that you accept and understand our financial and billing policy:

Patient

Responsible Party if different than patient Date

Patient Summary Form

PSF-750 (Rev:2/18/2009)

Instructions

Please complete this form within the specified timeline and fax to the specified fax number as indicated on Plan Summary or plan information previously provided.

*Fax number may vary by plan.

Patient Information

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Female	<input type="text"/>
Patient name Last	First	MI	<input type="radio"/> Male	Patient date of birth
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>
Patient address		City	State	Zip code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Patient insurance ID#	Health plan	Group number		
<input type="text"/>	<input type="text"/>	<input type="text"/>		
Referring physician (if applicable)	Date referral issued (if applicable)	Referral number (if applicable)		
<input type="text"/>	<input type="text"/>	<input type="text"/>		

Provider Information

<input type="text"/>		<input type="text"/>	
1. Name of the billing provider or facility (as it will appear on the claim form)		2. Federal tax ID(TIN) of entity in box #1	
<input type="text"/>		<input type="text"/>	
3. Name and credentials of the individual performing the service(s)		4. Alternate name (if any) of entity in box #1	
<input type="text"/>		<input type="text"/>	
5. NPI of entity in box #1		6. Phone number	
<input type="text"/>		<input type="text"/>	
7. Address of the billing provider or facility indicated in box #1		8. City	
<input type="text"/>		<input type="text"/>	
9. State		10. Zip code	
<input type="text"/>		<input type="text"/>	

Provider Completes This Section:

<p>Date you want THIS submission to begin:</p> <input type="text"/>	<p>Cause of Current Episode</p> <p>(1) Traumatic (4) Post-surgical (2) Unspecified (5) Work related (3) Repetitive (6) Motor vehicle</p>	<p>Date of Surgery</p> <input type="text"/>	<p>Diagnosis (ICD code) Please ensure all digits are entered accurately</p> <p>1° <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>2° <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>3° <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>4° <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>
<p>Patient Type</p> <p>(1) New to your office (2) Est'd, new injury (3) Est'd, new episode (4) Est'd, continuing care</p>	<p>Type of Surgery</p> <p>(1) ACL Reconstruction (2) Rotator Cuff/Labral Repair (3) Tendon Repair (4) Spinal Fusion (5) Joint Replacement (6) Other _____</p>	<p>DC ONLY</p> <p>Anticipated CMT Level</p> <p>(1) 98940 (2) 98942 (3) 98941 (4) 98943</p>	
<p>Nature of Condition</p> <p>(1) Initial onset (within last 3 months) (2) Recurrent (multiple episodes of < 3 months) (3) Chronic (continuous duration > 3 months)</p>		<p>Current Functional Measure Score</p> <p>Neck Index <input type="text"/> DASH <input type="text"/> <input type="text"/> <input type="text"/></p> <p>Back Index <input type="text"/> LEFS <input type="text"/> <input type="text"/> (other)</p>	

Patient Completes This Section:

<p>Symptoms began on: <input type="text"/></p> <p>(Please fill in selections completely)</p> <p>1. Briefly describe your symptoms:</p> <hr/> <p>2. How did your symptoms start?</p> <hr/> <p>3. Average pain intensity:</p> <p>Last 24 hours: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain</p> <p>Past week: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain</p> <p>4. How often do you experience your symptoms?</p> <p>(1) Constantly (76%-100% of the time) (2) Frequently (51%-75% of the time) (3) Occasionally (26% - 50% of the time) (4) Intermittently (0%-25% of the time)</p> <p>5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)</p> <p>(1) Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely</p> <p>6. How is your condition changing, since care began at this facility?</p> <p>(0) N/A — This is the initial visit (1) Much worse (2) Worse (3) A little worse (4) No change (5) A little better (6) Better (7) Much better</p> <p>7. In general, would you say your overall health right now is...</p> <p>(1) Excellent (2) Very good (3) Good (4) Fair (5) Poor</p>	<p>Indicate where you have pain or other symptoms:</p>
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Patient Signature: X _____ **Date:** _____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- Ⓐ The pain comes and goes and is very mild.
- Ⓛ The pain is mild and does not vary much.
- Ⓒ The pain comes and goes and is moderate.
- Ⓜ The pain is moderate and does not vary much.
- Ⓔ The pain comes and goes and is very severe.
- Ⓟ The pain is very severe and does not vary much.

Sleeping

- Ⓐ I get no pain in bed.
- Ⓛ I get pain in bed but it does not prevent me from sleeping well.
- Ⓒ Because of pain my normal sleep is reduced by less than 25%.
- Ⓜ Because of pain my normal sleep is reduced by less than 50%.
- Ⓔ Because of pain my normal sleep is reduced by less than 75%.
- Ⓟ Pain prevents me from sleeping at all.

Sitting

- Ⓐ I can sit in any chair as long as I like.
- Ⓛ I can only sit in my favorite chair as long as I like.
- Ⓒ Pain prevents me from sitting more than 1 hour.
- Ⓜ Pain prevents me from sitting more than 1/2 hour.
- Ⓔ Pain prevents me from sitting more than 10 minutes.
- Ⓟ I avoid sitting because it increases pain immediately.

Standing

- Ⓐ I can stand as long as I want without pain.
- Ⓛ I have some pain while standing but it does not increase with time.
- Ⓒ I cannot stand for longer than 1 hour without increasing pain.
- Ⓜ I cannot stand for longer than 1/2 hour without increasing pain.
- Ⓔ I cannot stand for longer than 10 minutes without increasing pain.
- Ⓟ I avoid standing because it increases pain immediately.

Walking

- Ⓐ I have no pain while walking.
- Ⓛ I have some pain while walking but it doesn't increase with distance.
- Ⓒ I cannot walk more than 1 mile without increasing pain.
- Ⓜ I cannot walk more than 1/2 mile without increasing pain.
- Ⓔ I cannot walk more than 1/4 mile without increasing pain.
- Ⓟ I cannot walk at all without increasing pain.

Personal Care

- Ⓐ I do not have to change my way of washing or dressing in order to avoid pain.
- Ⓛ I do not normally change my way of washing or dressing even though it causes some pain.
- Ⓒ Washing and dressing increases the pain but I manage not to change my way of doing it.
- Ⓜ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Ⓔ Because of the pain I am unable to do some washing and dressing without help.
- Ⓟ Because of the pain I am unable to do any washing and dressing without help.

Lifting

- Ⓐ I can lift heavy weights without extra pain.
- Ⓛ I can lift heavy weights but it causes extra pain.
- Ⓒ Pain prevents me from lifting heavy weights off the floor.
- Ⓜ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- Ⓔ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- Ⓟ I can only lift very light weights.

Traveling

- Ⓐ I get no pain while traveling.
- Ⓛ I get some pain while traveling but none of my usual forms of travel make it worse.
- Ⓒ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- Ⓜ I get extra pain while traveling which causes me to seek alternate forms of travel.
- Ⓔ Pain restricts all forms of travel except that done while lying down.
- Ⓟ Pain restricts all forms of travel.

Social Life

- Ⓐ My social life is normal and gives me no extra pain.
- Ⓛ My social life is normal but increases the degree of pain.
- Ⓒ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- Ⓜ Pain has restricted my social life and I do not go out very often.
- Ⓔ Pain has restricted my social life to my home.
- Ⓟ I have hardly any social life because of the pain.

Changing degree of pain

- Ⓐ My pain is rapidly getting better.
- Ⓛ My pain fluctuates but overall is definitely getting better.
- Ⓒ My pain seems to be getting better but improvement is slow.
- Ⓜ My pain is neither getting better or worse.
- Ⓔ My pain is gradually worsening.
- Ⓟ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back
Index
Score