

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"/>				
4. Alternate name (if any) of entity in box #1					5. NPI of entity in box #1				
<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>
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------

Patient Signature: X **Date:** _____

THE LOWER EXTREMITY FUNCTIONAL SCALE

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb
 Problem for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, do you or would you have any difficulty at all with:

Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1 Any of your usual work, housework, or school activities.	0	1	2	3	4
2 Your usual hobbies, recreational or sporting activities.	0	1	2	3	4
3 Getting into or out of the bath.	0	1	2	3	4
4 Walking between rooms.	0	1	2	3	4
5 Putting on your shoes or socks.	0	1	2	3	4
6 Squatting.	0	1	2	3	4
7 Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8 Performing light activities around your home.	0	1	2	3	4
9 Performing heavy activities around your home.	0	1	2	3	4
10 Getting into or out of a car.	0	1	2	3	4
11 Walking 2 blocks.	0	1	2	3	4
12 Walking a mile.	0	1	2	3	4
13 Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14 Standing for 1 hour.	0	1	2	3	4
15 Sitting for 1 hour.	0	1	2	3	4
16 Running on even ground.	0	1	2	3	4
17 Running on uneven ground.	0	1	2	3	4
18 Making sharp turns while running fast.	0	1	2	3	4
19 Hopping.	0	1	2	3	4
20 Rolling over in bed.	0	1	2	3	4
Column Totals:					

Minimum Level of Detectable Change (90% Confidence): 9 points

SCORE: _____ / 80

Please submit the sum of responses.

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