

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

Neck Index

ACN Group, Inc. Form NI-100

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

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck 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

- ⓪ I have no pain at the moment.
- ① The pain is very mild at the moment.
- ② The pain comes and goes and is moderate.
- ③ The pain is fairly severe at the moment.
- ④ The pain is very severe at the moment.
- ⑤ The pain is the worst imaginable at the moment.

Sleeping

- ⓪ I have no trouble sleeping.
- ① My sleep is slightly disturbed (less than 1 hour sleepless).
- ② My sleep is mildly disturbed (1-2 hours sleepless).
- ③ My sleep is moderately disturbed (2-3 hours sleepless).
- ④ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

- ⓪ I can read as much as I want with no neck pain.
- ① I can read as much as I want with slight neck pain.
- ② I can read as much as I want with moderate neck pain.
- ③ I cannot read as much as I want because of moderate neck pain.
- ④ I can hardly read at all because of severe neck pain.
- ⑤ I cannot read at all because of neck pain.

Concentration

- ⓪ I can concentrate fully when I want with no difficulty.
- ① I can concentrate fully when I want with slight difficulty.
- ② I have a fair degree of difficulty concentrating when I want.
- ③ I have a lot of difficulty concentrating when I want.
- ④ I have a great deal of difficulty concentrating when I want.
- ⑤ I cannot concentrate at all.

Work

- ⓪ I can do as much work as I want.
- ① I can only do my usual work but no more.
- ② I can only do most of my usual work but no more.
- ③ I cannot do my usual work.
- ④ I can hardly do any work at all.
- ⑤ I cannot do any work at all.

Personal Care

- ⓪ I can look after myself normally without causing extra pain.
- ① I can look after myself normally but it causes extra pain.
- ② It is painful to look after myself and I am slow and careful.
- ③ I need some help but I manage most of my personal care.
- ④ I need help every day in most aspects of self care.
- ⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

- ⓪ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ④ I can only lift very light weights.
- ⑤ I cannot lift or carry anything at all.

Driving

- ⓪ I can drive my car without any neck pain.
- ① I can drive my car as long as I want with slight neck pain.
- ② I can drive my car as long as I want with moderate neck pain.
- ③ I cannot drive my car as long as I want because of moderate neck pain.
- ④ I can hardly drive at all because of severe neck pain.
- ⑤ I cannot drive my car at all because of neck pain.

Recreation

- ⓪ I am able to engage in all my recreation activities without neck pain.
- ① I am able to engage in all my usual recreation activities with some neck pain.
- ② I am able to engage in most but not all my usual recreation activities because of neck pain.
- ③ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ④ I can hardly do any recreation activities because of neck pain.
- ⑤ I cannot do any recreation activities at all.

Headaches

- ⓪ I have no headaches at all.
- ① I have slight headaches which come infrequently.
- ② I have moderate headaches which come infrequently.
- ③ I have moderate headaches which come frequently.
- ④ I have severe headaches which come frequently.
- ⑤ I have headaches almost all the time.

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

Neck
Index
Score