Patient Registration Form

Name _____ Social Security # _____

Nickname _____ Date of Birth _____ ☐ Male ☐ Female

Address _____ City _____ State _____ Zip _____

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other

Employment Status ☐ NA ☐ Employed ☐ Student ☐ Retired

Phone # _____ Secondary Phone # _____

Email _____

Place of Employment_____ Phone #_____

Referring Physician _____ Primary Care Physician _____

HIPAA Information

(Please initial)

I was offered a copy of the Notice of Privacy Practices..... X_____

I agree to release medical or other information to process claim.. X_____

I agree to accept assignment of payment..... X_____

I give the office permission to leave a message..... X_____

Emergency Contact

1. Name _____ Relationship _____ Phone _____

   I give permission to discuss my: ☐ Appointments ☐ Medical Condition

2. Name _____ Relationship _____ Phone _____

   I give permission to discuss my: ☐ Appointments ☐ Medical Condition

Please fill out if you are not the insurance cardholder:

Subscriber's Name: _____ Subscriber's DOB: _____

Relationship to Patient _____ Place of Employment _____

Work Comp/Auto Information

Insurance Company _____ Phone #_____

Case Manager _____ Claim # _____

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, physician, physician assistant, dentist 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.

Cancellation Policy: Physical Therapy One requires 24-hour notice for any cancellation. A **$50.00** fee will be charged to your account for canceling or not showing for your appointment. If you have more than 3 (three) cancellations/no-shows it will result in an automatic discharge. We do have an answering machine if you need to leave a message regarding your appointment.

Sign _____ **Date** _____

Medical History

Existing or Relevant Previous Conditions

Allergies	◯ Yes ◯ No	Dizzy Spells	◯ Yes ◯ No	MRSA	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Emphysema/Bronchitis	◯ Yes ◯ No	Multiple Sclerosis	◯ Yes ◯ No
Anxiety	◯ Yes ◯ No	Fibromyalgia	◯ Yes ◯ No	Muscular Disease	◯ Yes ◯ No
Arthritis	◯ Yes ◯ No	Fractures	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Gallbladder Problems	◯ Yes ◯ No	Parkinsons	◯ Yes ◯ No
Autoimmune Disorder	◯ Yes ◯ No	Headaches	◯ Yes ◯ No	Rheumatoid Arthritis	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Hearing Impairment	◯ Yes ◯ No	Seizures	◯ Yes ◯ No
Cardiac Conditions	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Smoking	◯ Yes ◯ No
Cardiac Pacemaker	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Speech Problems	◯ Yes ◯ No
Chemical Dependency	◯ Yes ◯ No	High/Low Blood Pressure	◯ Yes ◯ No	Strokes	◯ Yes ◯ No
Circulation Problems	◯ Yes ◯ No	HIV/AIDS	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Currently Pregnant	◯ Yes ◯ No	Incontinence	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Depression	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Vision Problems	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Metal Implants	◯ Yes ◯ No		

Describe any other conditions

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions

Fall History

Injury as a result of a fall in the past year? ◯ Yes ◯ No

Two or more falls in the last year? ◯ Yes ◯ No

Patient is at risk for falls? ◯ Yes ◯ No

Surgical History

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Current Medications

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

☐ **Currently not taking any medications**

PHYSICAL THERAPY ONE
FINANCIAL AND INSURANCE BILLING POLICY

PHYSICAL THERAPY ONE 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, co-pays, 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, VISA, AND DISCOVER PAYMENTS, CASH OR CHECKS. We can also set up payment arrangements. **If we receive your check back from the bank for insufficient funds, you will be charged a $25.00 fee. If your account was to be sent to collections, you will be responsible for any additional fees incurred.**

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 co-pays 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