Back In Form Physical Therapy Registration Form

Today's Date_____ Referring Physician_____

Patient Full Name_____DOB_____Age____

Social Security #_____-_____-_____ Sex □ Male □ Female

Mailing Address_____

Occupation_____Employer_____

E-mail Address_____Chief Complaint_____

Why did you choose our facility? □ MD Referral □Former Patient □Website

□Location □Yellow Pages □Local Ad_____ □Other_____

Is the injury work related? □Yes □No Are you receiving home health? □Yes □No

Home Phone #_____Work Phone#_____
Cell Phone#_____

Emergency Contact Name and Phone Number_____

Primary Insurance_____ Subscriber Name:_____

Subscriber Date of Birth:_____ Subscriber SSN#:_____

Group / Policy #:_____

Secondary Insurace_____ Subscriber Name:_____

Subscriber Date of Birth:_____ Subscriber SSN#:_____

Group / Policy #:_____

I authorize the office of, Back in Form Physical Therapy Inc., to file my insurance claim and receive payments for services rendered. I understand that I am responsible for any co-pays, deductibles, or percentages that my insurance does not cover. Due to federal anti-kickback laws, we are legally prohibited from writing off deductibles, patient co-insurance as directed by your insurance carrier, or co-payments. If your insurance policy pays the patient instead of the provider, we will need to collect your payment at time of service. I understand that if I do not have insurance coverage, payment is due at time of service unless other arrangements are made with this office. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information.

_____ _____

Patient / Responsible Party Signature Date

Wellness, Prevention & Performance Enhancement

BACK IN FORM
PHYSICAL THERAPY

Name: _____ Age: ____ Date of next Dr's appointment: ___/___/___

Referring Physician: _____ Doctor's Diagnosis: _____

Your main concern: _____

Are you presently working? ☐ YES ☐ NO What is/was your Occupation? _____

Was your injury a result of an automobile accident? ☐ YES ☐ NO

Is the injury work related? ☐ YES ☐ NO. Is there an attorney involved? ☐ YES ☐ NO.

Date Of Injury ___/___/___ Employer:_____ Phone:_____

** Are you currently having Home Health? ☐ YES ☐ NO

Please check any of the following whose care you are under: ☐ Physical Therapist ☐ Chiropractor

☐ Psychiatrist/Psychologist ☐ Medical Doctor/Osteopath ☐ Other:_____

Have you, for any reason had out patient physical therapy this calendar year? ☐ Yes or ☐ No

If Yes — approximately how many visits ? _____

Have you had any of the following tests for THIS condition? (If yes, please list date): ___/___/___

☐ XRays, ☐ MRI, ☐ CAT scan, ☐ Bone Scan, ☐ Nerve/Muscle test ☐ Other _____

Please list any surgeries (in/out patient) and any conditions for which you have been hospitalized and the dates:

_____ ___/___/___ _____ ___/___/___

_____ ___/___/___ _____ ___/___/___

During the past month have you been feeling down, depressed or felt hopeless? ☐ YES ☐ NO

During the last month have you been bothered by having little interest or pleasure in doing things? ☐ YES ☐ NO

Are you currently being treated by a physician for any heart related disorder ? ☐ Yes ☐ No

If so, what was the diagnosis? _____

How many days per week do you drink alcohol? _____

If one drink equals one beer or glass of wine, how much do you drink at an average sitting? _____

Have you had a fall in the last year? ☐ YES ☐ NO

If so, approx. how many falls have you had in the last year? _____

If you had a fall in the last year, was an injury sustained? ☐ YES ☐ NO

If yes, please describe:_____

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Women: Are you currently pregnant or think you might be pregnant? ☐ YES ☐ NO

Which of the Over-the-Counter medicines have you taken in the last week? Please check those that apply.

☐ Aspirin ☐ Tylenol ☐ Advil/Motrin/Ibuprofen

☐ Antihistamines ☐ Antacid ☐ Vitamins/Mineral Supplements

Laxatives, Decongestants, Herbals--Please Specify_____

Please list any PRESCRIPTION medications you are taking (Including pills, injections, and/or patches):

1._____ 2._____ 3._____

4._____ 5._____ 6._____

Have you EVER been diagnosed as having any of the following conditions? Please check those that apply.

☐ Seizures/Epilepsy ☐ Cancer ☐ Diabetes ☐ Vision/Hearing Problems ☐ Headaches

☐ Osteoporosis ☐ Stroke/TIAs ☐ High Blood Pressure ☐ Heart Problems ☐ Pacemaker

☐ Rheumatoid Arthritis ☐ Hepatitis ☐ Anemia ☐ Tuberculosis ☐ Alzheimer's

☐ Circulation Problems ☐ Sleeping Problems ☐ Depression ☐ Weight/Energy Loss ☐ Asthma

☐ Emphysema/Bronchitis ☐ Parkinson's ☐ Chemical Dependency ☐ Thyroid Problems ☐ Multiple Sclerosis

☐ Gout ☐ Dehydration ☐ Orthopedic Surgery ☐ Urinary/Fecal Incontinence

Have you recently noted:

Weight loss/gain ☐ YES ☐ NO

Weakness ☐ YES ☐ NO

Nausea/Vomiting ☐ YES ☐ NO

Fever/chills/sweats ☐ YES ☐ NO

Dizziness/Lightheadedness ☐ YES ☐ NO

Numbness or Tingling ☐ YES ☐ NO

Fatigue ☐ YES ☐ NO

Night Pain ☐ YES ☐ NO

Please indicate your goals for physical therapy: _____

_____

Pain Scale - Please rank your pain on this 0-10 scale. Zero is pain free, 10 is the worst pain.

☐ 1 - No Pain ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 - Worst

What aggravates your pain? ☐ Sitting ☐ Rise from sit ☐ Standing ☐ Lying Down ☐ Overhead Activity

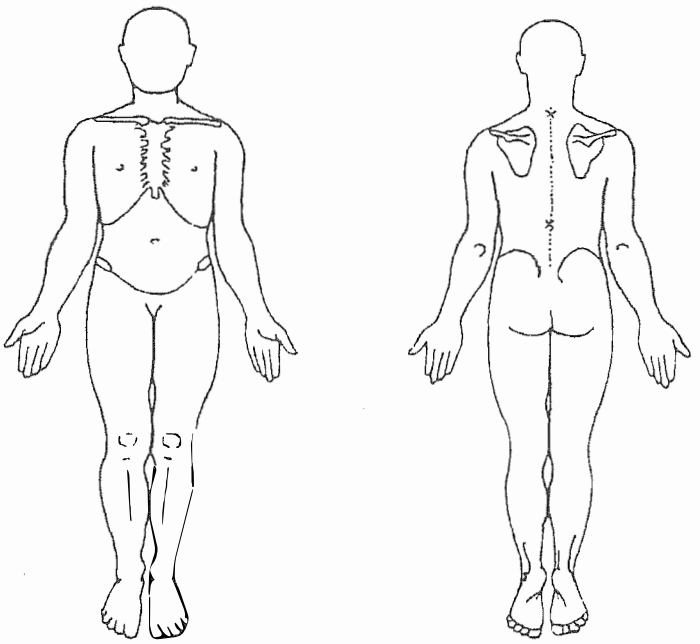
☐ Lifting ☐ Bending ☐ Walking ☐ Running ☐ Stairs ☐ Squatting ☐ Dressing ☐ Stress ☐ Cough/

Sneeze ☐ Turning Head ☐ Driving ☐ Looking Up/Down ☐ Other_____

What eases your pain? ☐ Rest ☐ Ice ☐ Heat ☐ Changing positions ☐ Medications ☐ Other_____

Please draw in your complaint using the diagram and markings. Also draw other pain areas that you have at this time.

Ache	Burning	Pins and Needles	Throbbing	Other/General Pain
^^^^^^^^	=======	oooooooooo	//////////////////	XXXXXXX
^^^^^^^^	=======	oooooooooo	//////////////////	XXXXXXX



I do hereby state that the above information is accurate and true to the best of my knowledge.

_____ ___/___/___

Signature of Patient or Guardian Date

(If other than patient, please list relationship) _____

FOR THERAPIST USE ONLY

Reviewed by Therapist: _____ Date:_____

Wellness, Prevention & Performance Enhancement

BACK IN FORM
PHYSICAL THERAPY

Notice of Exclusions from Medicare Benefits (NEMB)

There are items and services for which Medicare will not pay

- Medicare does not pay for all of your health care costs. Medicare only pays for covered benefits. Some items and services are not Medicare benefits and Medicare will not pay for them.
- When you receive an item or service that is not a Medicare benefits, you are responsible to pay for it personally or through any other insurance that you may have.
- Medicare will not pay for Physical Therapy if you are currently receiving Home Health Care.

Patient Signature _____ Date: _____

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BACK IN FORM
PHYSICAL THERAPY

Cancellation & No Show Policy

On your first visit to Back In Form Physical Therapy, your therapist will complete an evaluation. At the end of your evaluation, your therapist will explain the frequency and type of treatment you will receive. For example, clinical sessions 2-3x week for 4 weeks, with independent exercise program. Physical therapy is an intense, but brief treatment program for maximum pain relief and the goal of returning to the highest level of function possible. Missing one or two of your recommended appointments in a week will not allow these goals to be met.

If you are unable to attend one of your appointments, kindly give us 24 hours notice. It is in your best interest to make up that missed appointment. If you do not call to cancel within 24 hours and fail to show, you will incur a **$35.00 no show fee**.

If you miss 3 scheduled appointments, a notice will be sent to your referring physician informing him/her that the treatment plan has not been adhered to. It is the therapists discretion to continue treatment or discharge you from therapy. We will always take into consideration illness, hospitalization, family emergencies and uncontrollable circumstances.

If you are going to be late for an appointment, please notify us so that we can adjust or schedule accordingly. Please understand we will try to administer your full treatment, however, time restraints may limit this. Failure to notify us will result in a **$35.00 late fee**.

It is our desire to work with you and your physician to address your needs and goals in the most effective way possible. We greatly appreciate your cooperation and look forward to helping you achieve a better quality of life. If you have any questions, please feel free to ask any of the Back In Form Physical Therapy Staff.

Patient Signature _____ Date _____

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BACK IN FORM
PHYSICAL THERAPY

Privacy and Assignment of Benefits

Auto Accident – If your health problem is the result of an auto accident, you must provide us with your auto insurance and major medical policy information. We will file with your auto carrier if you have opened a med pay claim, otherwise, we will file with your medical insurance. We do not file with third party payors. You have the option to self-pay should you choose not to file with your med pay or medical insurance.

Informed Consent – I understand as a patient of Back In Form Therapy.....

- I have the right to receive complete and current information concerning my diagnosis, treatment and any known prognosis. This information will be communicated to me in terms I can understand by my therapist.
- I have the right to accept medical care or to refuse treatment to the extent permitted by law and to be informed of the medical consequences if I refuse treatment. I understand that if I refuse recommended treatment, Back In Form Physical Therapy has the right to discharge me from therapy.
- I will be informed if Back In form Physical Therapy wishes to participate in or perform any research or educational projects that would affect my care. I understand that I have the right to choose whether I participate. I will receive the most effective care the clinic can provide.
- Patients Rights will be posted in a prominent location for my review and I can discuss any questions with my therapist.

Privacy Policy – I understand there is a copy of Back In Form Physical Therapy Privacy Practices posted and it is my right to request a copy. I also understand that as part of treatment, payment, or health care operations, it may become necessary to disclose my health information to another entity (my doctor, insurance company, case manager, etc) and I consent to such disclosure for these permitted uses, including via fax.

Is there anyone involved in your care or payment related to your care that we can share information with? If yes, Contact Name & Number _____.

Assignment of Benefits – I hereby assign all benefits directly to Back In Form Physical Therapy and also authorize release of any medical records necessary to process medical claims. I understand fully that in the event my insurance company or financially responsible party does not pay for the services, I will be financially responsible for payment.

Patient Signature _____ Date _____

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Appointment Reminder Consent

Please complete this form and sign below giving Back In Form Physical Therapy permission to provide automatic appointment reminder service by email or by cell phone text message.

Step One: Select One Option Below

☐ Please send **email messages** to confirm my upcoming appointments to:

_____

☐ Please send cell phone **text messages** to confirm my upcoming appointments to:

_____

I recognize that normal text messaging rates may apply.

Step Two: If you would like text messages instead of email reminders, please indicate your Cell Phone Carrier.

We cannot set your account up to send email text message reminders without knowing your cell phone carrier. Please indicate your carrier below, if you would like text message reminders:

- ☐ ALLTel
- ☐ AT&T
- ☐ Boost Mobile
- ☐ Cingular
- ☐ Cricket Wireless
- ☐ Metrocall
- ☐ MetroPCS
- ☐ Nextel
- ☐ Qwest
- ☐ Sprint PCS
- ☐ T Mobile
- ☐ US Cellular
- ☐ Verizon
- ☐ Virgin Mobile

Patient Name: _____

Signature of Patient or Guardian: _____

Date: _____