

Patient Registration Form



Patient Information

Full First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: ____/____/____ Sex: _____

Home Address: _____
(Street) (City/State/Zip)

Billing Address: _____
(If different from home address) (Street) (City/State/Zip)

Home Phone: (____) ____ - ____ Mobile Phone: (____) ____ - ____

Work Phone: (____) ____ - ____ E-Mail Address: _____

Would you be interested in having communications sent to you via your e-mail address? (Examples: Appointment reminders, administrative updates, and health bulletins): **YES** **NO**

Marital Status (Circle or Check One): Married Single Divorced Widow

Employer Name: _____ Employer Phone Number: (____) ____ - ____

Referring Physician: _____ Office Phone #: (____) ____ - ____
(Name)

Injury Type: Work Auto Home Other _____

Lawyer Involved? Yes No

Attorney Name: _____ Office Phone #: (____) ____ - ____

Address: _____
(Street) (City/State/Zip)

How did you hear about our practice? _____

Who to call for an emergency:

Name: _____ Relationship: _____

Home Phone: (____) ____ - ____ Work Phone: (____) ____ - ____

Primary Insurance Information

Plan Name: _____ I.D. Number: _____

Secondary Insurance Information

Plan Name: _____ I.D. Number: _____

Signature: _____ **Date:** _____

CONSENT FOR CARE & TREATMENT:

I do hereby consent to rehabilitation and related services at FACILITY. In so doing, I understand there are no guarantees to the result of treatment. I have been given the opportunity to ask questions and my questions have been answered to my satisfaction

SCHEDULING:

In order to secure the appointment times that you desire, **we recommend that you schedule through at least two (2) weeks of appointments**, or up to the length of your prescription.

RESCHEDULING:

If you must reschedule your appointment, **we require a 24-reschedule notice**. This will allow another patient to utilize the time slot.

CANCELLATION/NO SHOW POLICY:

Our office requires **24 hr notice for cancelling an appointment**. If we do not receive notice of cancellation within 24 hrs a **\$50 cancellation/no show fee** will be charged for that visit.

OFFICE POLICY ON PAYMENT:

It is our policy to require payment of all office charges at the time they are given, unless prior arrangements have been specifically made.

We have calculated your **ESTIMATED** patient portion for each visit to be \$_____. This amount is based off of information gathered from your insurance company.

1° Deductible:_____ Ded Met:_____ Copay/Co-insurance:_____ Visit limits:_____

2° Deductible:_____ Ded Met:_____ Copay/Co-insurance:_____ Visit limits:_____

The amount stated above will be collected from you before each visit. All additional amounts owed as patient responsibility will be billed to you each month in an itemized patient statement.

We have calculated your **AGREED** patient portion to be \$_____ a visit towards your deductible up to \$_____ then \$_____ for each visit after the deductible is met.

INSURANCE POLICY:

Insurance provides for your reimbursement on allowed medical charges. As a courtesy to you we will provide an itemized statement you may send to your insurance company for payment. We will be happy to submit to most insurance carriers, if you have provided us with policy numbers, address, place of employment and any other pertinent information. **You are responsible for all deductibles and charges not covered by insurance**. Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility.

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I authorize the Doctor to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the Doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information.

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Office Policy Form

ELECTRONIC SUBMISSION OF MEDICAL INFORMATION:

I understand if I want a copy of my medical information or financial account history I will have the opportunity to provide my verbal authorization to receive that information via email at the time of the request. Email is not considered secure by HIPAA guidelines. My signature on this form indicates my understanding that by opening such an email, I gave verbal authorization to receive, I have also given written authorization. I am aware of any risk this may pose to my PHI.

PRIVACY PRACTICES:

I have been provided with a copy (or the option to read the in office copy) of Ann Steinfeld Physical Therapy's HIPAA Privacy Practices Policy and I understand the information within. _____ *(Initial)*

I have read the above and accept financial responsibility in full for this account.

SIGNED: _____
Patient, Parent, or Guardian

DATE: _____

ANN P.T.

MEDICAL HISTORY

(Mark pain on diagram)

Name _____

Reason for Therapy _____

Describe injury or onset of condition _____

Have you had previous therapy for this condition _____

When is Your next Doctor's Appointment? _____

Date of Injury/Onset _____

Surgical Procedure & Date _____

Are you currently experiencing or have you ever experienced any of the following?

Diabetes	yes () no ()	Kidney Problems	yes () no ()
High Blood Pressure	yes () no ()	Nervous disorders	yes () no ()
Heart Disease	yes () no ()	Pregnant / IUD	yes () no ()
Heart Attack	yes () no ()	Allergies / Skin	yes () no ()
Pacemaker	yes () no ()	Previous Surgery	yes () no ()
Headaches	yes () no ()	Hernia	yes () no ()
Seizure	yes () no ()	Metal Implants	yes () no ()
Cancer	yes () no ()	Shortness of Breath	yes () no ()
Stroke	yes () no ()	Asthma	yes () no ()
Heart Murmur	yes () no ()	Heart Arrythmia	yes () no ()
Injured in a Motor Vehicle Accident	yes () no ()	Any previous injury	yes () no ()

Have you had any of the following test?: X-Rays MRI CT Scan EMG Other _____

If yes on any of the above please explain & give approximate dates _____

Are you currently taking medications? Yes / No What kind / condition _____

Type of pain: sharp / burning / aching / tingling / numbness / other _____

Does pain radiate to arms and legs _____

Rate present pain on a 1-10 scale (1=minimal 10=severe) _____

Does rest relieve your pain Yes / No Does pain awaken you Yes / No _____ times / night

What aggravates your pain most sitting / standing / walking / other _____

What positions are most comfortable _____

Can you drive? yes / no Can you climb stairs? yes / no Are you able to provide self-care? yes / no

What other details you can tell us about your injury or condition _____

Signed: _____ Date: _____



ANN STEINFELD PHYSICAL THERAPY

Consent to Therapeutic Procedures

I, _____ hereby consent to therapeutic procedures outlined below, to be performed by Ann Steinfeld Physical Therapy, and their associates.

_____ Evaluation and treatment of neuromusculoskeletal dysfunction & or pain.

_____ Evaluation and treatment of functional loss.

_____ Other: _____.

This procedure has been explained to me in terms that I can understand and included the following about the proposed evaluation and treatment.

1. The nature and extent of the procedure to be performed.
2. Risks involved, if any, in evaluation or treatment.
3. Treatment may include, but is not limited to: stretching, exercise in the clinic and at home, postural and body mechanics training, gait training, joint and soft tissue mobilization, heat, ice, electrical stimulation, iontophoresis, ultrasound, traction, taping, and orthotics.

I have asked all the questions I thought were important in deciding whether or not to undergo evaluation and treatment. Those questions have been answered to my satisfaction.

I understand no assurance can be given that the outcome of the treatment will be successful. I acknowledge that no guarantee or warranty of success has been given to me.

I understand that I may consult with other therapists and / or physicians at any time regarding my condition. I have the right to refuse any therapeutic procedure and treatment, at any time.

I certify that I have read the above consent statement, that the explanations therein referred to were made by _____ and are understood by me, that all blanks or statements requiring insertion were filled in prior to the time of my signature, and that this consent is given freely, voluntarily, and without reservation.

Signature of Patient / Responsible Party

Date

Witness Signature

Date

PAIN EVALUATION

Patient Name: _____

Please rate your pain on a scale of 1-10, with 10 being the worst (CIRCLE):

0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____
 No pain Very Weak Weak Moderate Somewhat Strong Strong Very Strong Very Strong Emergency Room

Use the Drawing Below to Mark Your Areas of Pain:

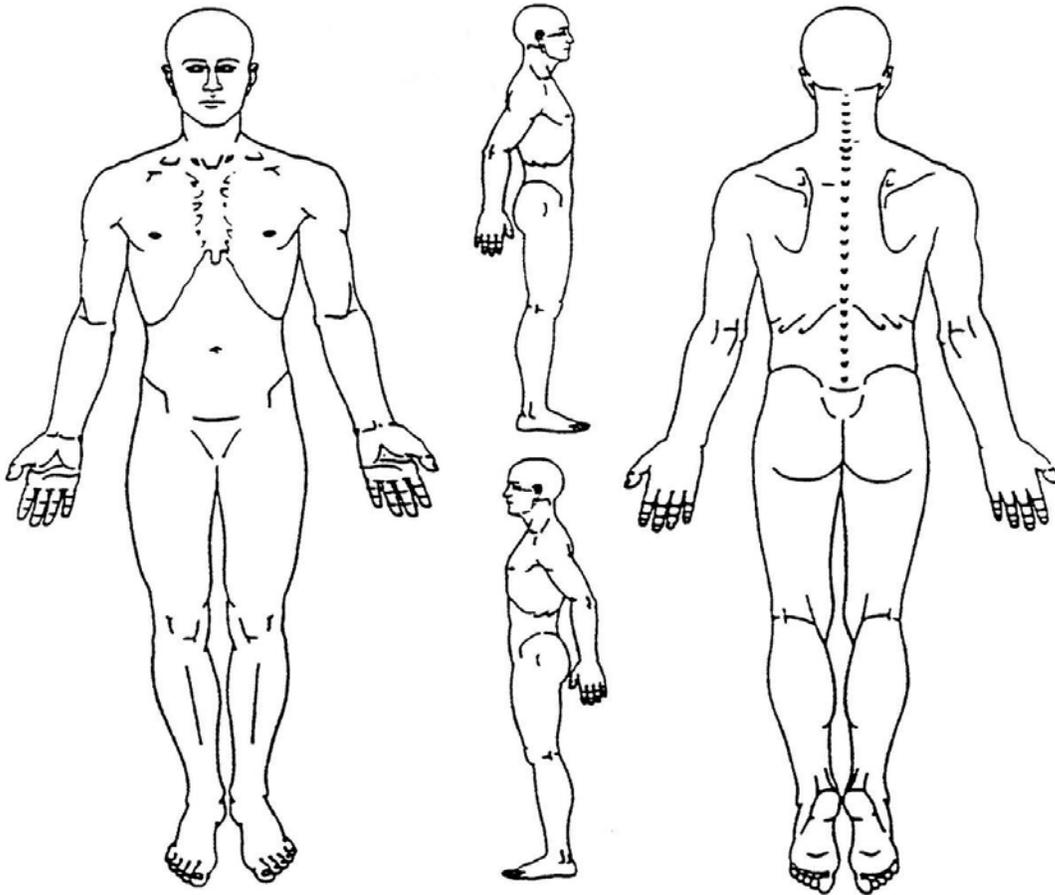
N= Numbness

P= Pins and Needles

S=Stabbing

T=Tingling

A=Dull Ache



Describe your symptoms in order of severity, with worse symptom being #1.

1: _____ 2: _____

3: _____ 4: _____

When did symptoms begin? Month: _____ Day: _____ Year: _____

Result of: Motor Vehicle Accident Work Related Other: _____

Getting: Better Worse Staying the Same

Patient's Signature: _____