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: _____________________

Patient Registration Form

Ann Steinfeld
Physical Therapy

Person responsible for bill or PARENT (Complete only if different from patient)

Guarantor Name: ________________________________ Social Security Number: _____-____-_____

Relationship to Patient: (please check): Spouse Mother Father Other____________________

Date of Birth:____/_____/_____ Is your address same as the patient? Yes No (If not, provide below)

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

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

Employer Name: _______________________ Employer Phone Number: (____) ______-_______

Employer Address: ____
(Street) (City/State/Zip)

Signature of Responsible Party: ___________________________________ Date: ________________

Office Policy Form

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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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:____ **DATE:** _______________
Patient, Parent, or Guardian

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

ANN PT

PAIN EVALUATION

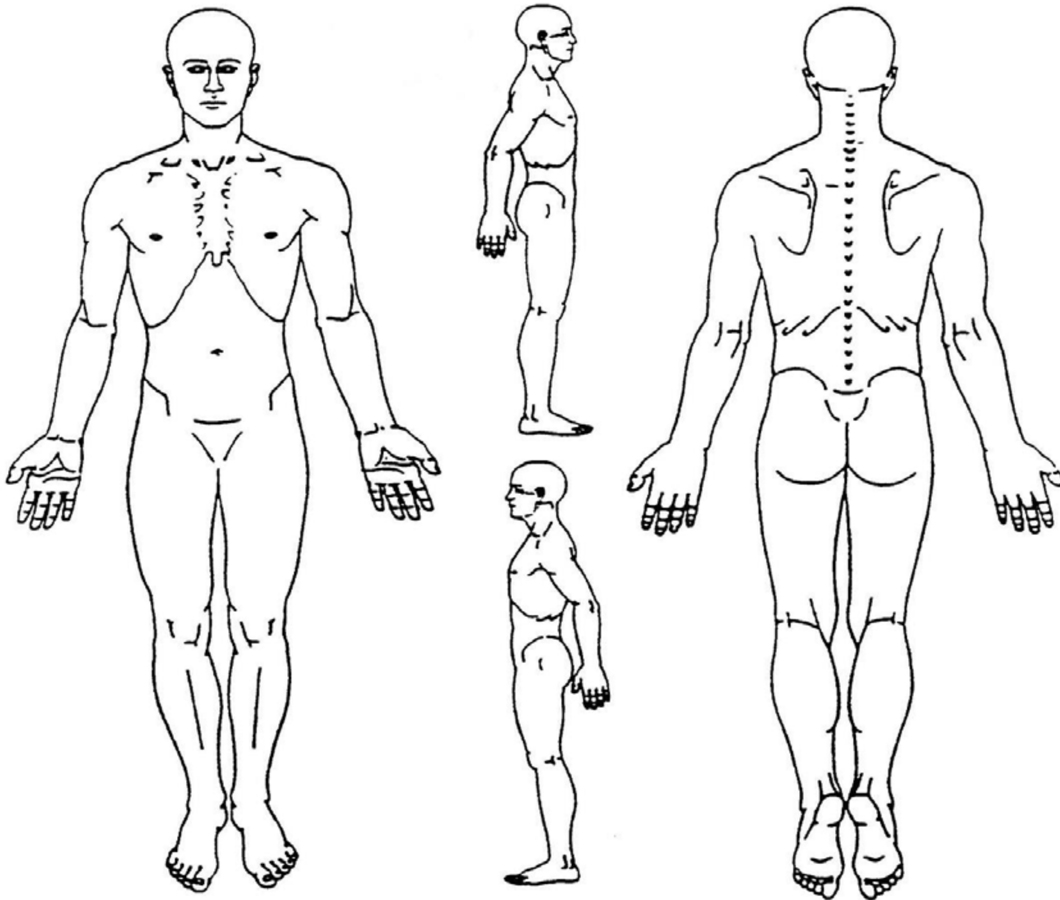
Patient Name:___________________________

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 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:________________________________