PHYSICAL THERAPY WAY

Patient Registration

Patient Information

Patient Name: _____ DOB: _____ Sex: ____
Last First M.I.

Phone: _____ Cell: _____ Permission to send appointment reminders

Address: _____
Street Address Apt./Unit #

_____
City State Zip Code

Social Security Number: _____ Email: _____

Employer: _____ Occupation: _____

Spouse: _____ Spouse Phone: _____

Guardian Information

Guardian Name: _____ DOB: _____ Relationship: _____

Emergency Contact

Contact Name: _____ Relationship: _____

Phone: _____ Cell: _____

CONSENT TO TREATMENT

1. I hereby authorize the release of medical information necessary to process my insurance and authorize payment directly to the provider of services. I fully understand that I am financially responsible for any services not covered by this authorization.
2. I have presented myself to this facility for treatments and consent to diagnostic procedures and care provided by my attending therapist.
3. I realize I have the right to refuse any treatments or procedures in this facility. I acknowledge that medicine is not an exact science, no guarantees or warranties can be made to me regarding the results of any treatment at this facility. I understand that information from any medical record(s) kept by this facility may be used for educational, administrative, and/or facility approved purpose, but my personal identity will not be revealed.
4. I understand that a 12-hour notice of cancellation of appointments is required. Failure to cancel appointment (or a no show) can result in a $25 fee. I understand if I do not attend therapy for two weeks or miss three appointments that I am subject to discharge. Once I have been discharged, I understand that I will need a new physician's order/referral for further treatment if my insurance requires it and I will be receiving a new evaluation.

I have read and fully understand the above general consent form and any questions concerning my care have been answered to my satisfaction.

I have been offered a copy of Physical Therapy Way's privacy practice.

_____ _____
Signature of Patient (or guardian) Date

Current Medical Information

Referring Physician: _____ Primary Physician: _____

Reason for Visit: _____

Date of Onset: _____ Areas of body affected: _____

Are you latex sensitive? YES NO List any allergies we should know about: _____

Past Medical History

Please list ANY surgeries, significant injuries (including fractures, dislocations, sprains) or other conditions for which you have been treated or hospitalized for, including the approximate date and reason for the surgery or hospitalization.

Date of Injury	Reason for surgery/ hospitalization

Have you ever been diagnosed as having any of the following condition(s)

YES NO Heart Problems
YES NO High Blood Pressure
YES NO Circulation Problems
YES NO Diabetes
YES NO Kidney Disease
YES NO Thyroid Problems
YES NO Osteoporosis (low bone density)
YES NO Infectious Disease (Hepatitis, Tuberculosis, etc.)
YES NO Anemia
YES NO Pacemaker
YES NO Cancer
If YES, describe what kind _____

YES NO Asthma
YES NO Emphysema/Bronchitis/COPD
YES NO Chemical dependency
YES NO Multiple Sclerosis
YES NO Depression
YES NO Hepatitis
YES NO Tuberculosis
YES NO Stroke
YES NO Rheumatoid Arthritis
YES NO HIV/AIDS
YES NO Epilepsy
Other not listed _____

Please list any PRESCRIPTION medication(s) you are currently taking (including pills, injections, and or skin patches):

_____

_____

Have you experienced any of the following over the past few months?

YES NO Weight loss/ Gain
YES NO Nausea/vomiting
YES NO Fatigue
YES NO Dizziness
YES NO Night Pain
YES NO Unusual Weakness
YES NO Fever/chills/sweats
YES NO Numbness or Tingling
YES NO Chest or Arm pain
YES NO Changes in bowel/bladder

During the past few months have you been feeling down, depressed, or hopeless? YES NO
Do you smoke? YES NO If so, how many pack(s) of cigarettes do you smoke a day? _____
Have you fallen in the past year? YES NO If so, how many times? _____
FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO
PLEASE RATE YOUR PAIN on a scale of 0-10 (0 is no pain and 10 is emergency room pain)
Now ____/10 At worst ____/10 At best ____/10

_____ _____
Signature Date

Insurance Information

	Primary	Secondary
Insurance Company Name		
I.D. / Policy Number		
Group Number		
Policyholder Name		
Policyholder Address (if different than patient)		
Policyholder Date of Birth		

Motor Vehicle Accident YES NO	Worker's Comp Injury YES NO
Claim Number:	Claim Number:
Adjustor's Name:	Adjustor's Name:
Adjustor's Phone:	Adjustor's Phone:
Adjustor's Fax:	Adjustor's Fax:

_____ _____

Patient/Guardian Signature Date

PHI AND BILLING DISCLOSURES FOR INDIVIDUALS INVOLVED IN PATIENT CARE

There may be times when it is necessary for an individual directly involved in your care to call the facility to inquire about your personal health information.

I authorize Physical Therapy Way to disclose my health information that is directly related to my current treatment at this facility to the individual(s) listed below for the purposes of their role in my treatment or payment for the health services that I have received.

Name	Relationship

If you are a representative of a patient, indicate the scope of your authority to act on the patient's behalf:

_____

Please provide documentation or explanation of your authority to act for the patient:

_____

_____ _____

Signature of Patient Date

_____ _____

Signature of Witness Date