REGISTRATION FORM

(Please Print)

Today's Date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F

Street address:	Email:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Work phone no.: ( )

Chose clinic because/referred to clinic by (Please check one box):	☐ Dr.	☐ Insurance plan	☐ Hospital

☐ Family	☐ Friend	☐ Close to home/work	☐ Internet	☐ Other

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Name of Insurance Company:	Provider Services Phone # (on back of card):

Subscriber's name:	Birth date:	Group no.:	Policy no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Fortius Physical Therapy or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Medical History Form

Name: ______________________________ Date of Birth: _________________ _Date: __________________

History of Current Problem(s)

The date your problem(s) began (month/date/year): ____

What happened? ____

Have you ever had the problem(s) before?

☐ **Yes** Did the problem(s) get better? ☐ **Yes** ☐ **No**

About how long did it last? ____

☐ **No**

How are you taking care of the problem(s) now? ____

What makes the problem(s) worse? ____

What activities are you not able to do now that you could do before the problem(s)? Please be as specific as you can; for instance, "unable to reach over my head." ____

____

What are your goals for therapy? ____

Have you ever received physical therapy? ☐ **Yes** ☐ **No** If so, when and why? ________________________

____

Are you seeing another professional for the problem(s)? Check all that apply:

☐ Acupuncturist	☐ Occupational Therapist	☐ Cardiologist	☐ Orthopedist
☐ Chiropractor	☐ Osteopath	☐ Dentist	☐ Pediatrician
☐ Family Practitioner	☐ Internist	☐ Neurologist	☐ OBGYN
☐ Rheumatologist	☐ Podiatrist	☐ Massage Therapist	☐ Other _____________

Current Limitations. Please Check all that apply below.

☐ Difficulty with locomotion and/or movement:

☐ Bed Mobility

☐ Transfers (such as moving from the bed to a chair, bed to commode)

☐ Gait (walking)

☐ On level ☐ Stairs ☐ Ramps ☐ Uneven terrain

☐ Difficulty with self-care (bathing, dressing, eating, toileting)

☐ Difficulty with home management (household chores, shopping, driving)

☐ Difficulty with community and or work activities

☐ Difficulty with recreation sports

☐ Other ____

Employment

Occupation ____

☐ Full time ☐ Part time ☐ Full Duty/Modified Duty

Currently not working due to: ☐ Injury/Surgery ☐ Other ____________________________

Home Environment:

What type of home do you live in?

☐ One floor home ☐ More than one floor ☐ Stairs with railing ☐ Without railing ☐ Elevator

With whom do you live? ☐ Alone ☐ Spouse only ☐ Family Members ☐ Other _______________

Medications

Please list all prescription medications ____

____

List all over-the-counter medications ____

____

Medical History: Please check if you have ever had:

☐ Developmental or growth problems	☐ Kidney problems	☐ Broken bones
☐ Circulation/vascular problems	☐ Infectious disease	☐ Arthritis
☐ Low Blood Sugar/Hypoglycemia	☐ Lung problems	☐ Allergies
☐ Alcohol/Drug dependency	☐ Muscular Dystrophy	☐ Osteoporosis
☐ Repeated infections	☐ Seizures/Epilepsy	☐ Depression
☐ Ulcers/Stomach problems	☐ Blood disorders	☐ Head injury
☐ Diabetes/high blood sugar	☐ Multiple Sclerosis	☐ Cancer
☐ High Blood Pressure	☐ Stroke	☐ Parkinson's Disease
☐ Skin Diseases	☐ Other ____	

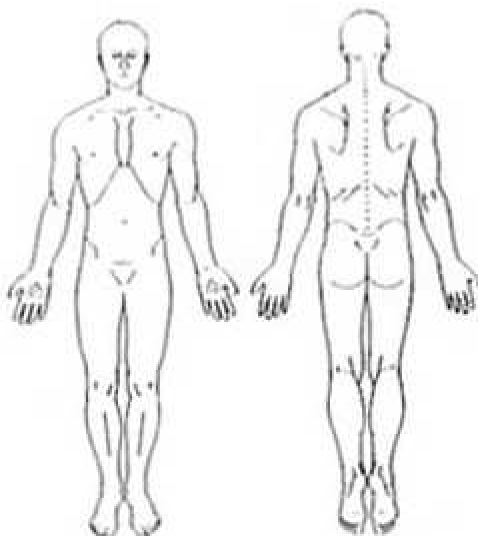
Surgeries

Please list any surgeries including year:

____

____

Please mark on the drawings below, the areas where you feel pain.



Pain Scale: On the line provided, please make where your "pain status" is today.

|---|

No Pain Most Severe Pain

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individuals' home.

I wish to be contacted in the following manner (check all that apply):

□ Home Telephone______________________
- □ O.K. to leave message with detailed information
- □ Leave message with call-back number only.

□ Work Telephone ______________________
- □ O.K. to leave message with detailed information
- □ Leave message with call-back number only

□ Written Communication
- □ O.K. to mail to my home address
- □ O.K. to mail to my work/office address
- □ O.K. to fax to this number __________

□ Other ____________________________
____

______________________________________ Patient Signature

______________________________ Date

______________________________________ Print Name

______________________________ Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Date	Disclosed to Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key: T=Treatment Records; P =Payment Information; O=Healthcare Operations
(3) Enter how disclosure was made: F=Fax; P=Phone; M=Mail; O=Other

(Rev. 04/04/2005)

Fortius Physical Therapy

Consent for Treatment

I agree and give Fortius Physical Therapy permission to furnish physical therapy to myself or my dependant, which is considered necessary and proper to treat myself or my dependant's condition.

Initials________

Assignment of Benefits

I authorize payment of medical insurance benefits to be made directly to Fortius Physical Therapy on my behalf for physical therapy services rendered. I also authorize Fortius Physical Therapy to release my protected health information for treatment and billing purposes.

Initials________

Notice of Privacy Practices

I have received a written copy of Fortius Physical Therapy's Notice of Privacy Practices. The notice provides, in detail, the uses and disclosures of my protected health information that may be available by Fortius Physical Therapy, my rights as a patient, and Fortius Physical Therapy's legal duties with respect to my protected health information.

Initials________

Financial Policy

As a courtesy, Fortius Physical Therapy will pre-verify your insurance benefits. Please note, unless you have secondary insurance all co-pays, deductibles, and/or co-insurance is the patient's/guardian's (in the case of a minor) responsibility. Co-pays are due at the time services are rendered. Your deductible/co-insurance will be billed to you once we receive an 'explanation of benefits' from your insurance carrier. The responsibility for any services not paid by your health insurance is patient responsibility.

Payment methods include cash, check, money order and credit card. Returned checks and balances older than 90 days are subject to additional charges.

Initials________

Cancellation/No-Show Policy

Fortius Physical Therapy urges you to keep your appointments as consistent treatment will lead to a speedy recovery. Non-compliance may result in discharge from therapy. In worker's compensation or motor vehicle accident cases, non-compliance must be reported to your adjuster. The effect of non-compliance affects our clinic hours and other patients scheduling prerogatives. We require 24 hours notice if you need to cancel an appointment. Patients who fail to show for an appointment or that do not provide greater than 24 hours notice will be subject to a $30 charge.

Initials________

Email authorization

I authorize Fortius Physical Therapy to correspond with me via email. This may include but is not limited to newsletters and clinical updates.

Initials_______

Email: ______________________________

Signature on File

I have read, gained understanding of, and agree with the above policies and procedures. I authorize this signature on all insurance submissions.

______________________________________ ________________________

Patient's/Guardian's Signature Date