Appointment Date/Time:_____Therapist:_____

Advantage Physical Therapy Patient Registration

******Please note <u>ALL</u> patients are required to have a prescription for Physical Therapy from a referring Physician prior to Appointment.******

Patient Name:	Employment/Student Status: Full time employed _____ Full time student _____ Part time employed _____Part time student _____ Unemployed _____ Retired _____ Other _____
Date of Birth: **Age:** **Sex: Female _____Male_____**	**Occupation:**
Address:	**Employer Name and Address:**
Home/Cell Phone:	**Email:**
Work Phone:	**Married_____ Single_____ Other_____**
Referring Physician:	
Emergency Contact Name: Primary Phone: Relation to patient:	**Is this injury related to**: Employment: ____Yes ____No Auto Accident: ____Yes ____No Date of injury: _____ State of accident: _____
Primary Insurance:	**Secondary Insurance:**
Policy Holder Name and **Date of Birth**	**Policy Holder Name and Date of Birth**
Policy Number or SSN:	**Policy Number or SSN**:
Policy Holder Employer:	Policy Holder Employer:
Policy Holder Address(if different from patient):	Policy Holder Address(if different from patient):
Policy Holder Phone Number:	Policy Holder Phone Number:
Relationship to Patient: Self___Spouse___Child___Parent___Other___	Relationship to Patient: Self___Spouse___Child___Parent___Other___

Patient Authorization

Patient name: Date of Birth:

Release of Information and Consent to Treatment

All information contained herein is true and correct.

I am aware of my diagnosis and wish to receive treatment at Advantage Physical Therapy Corporation. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to Advantage Physical Therapy to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment and/or payment for services provided.

I authorize Advantage Physical Therapy and/or its subsidiaries and affiliates to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

The signature below certifies that I have read and understand the above information.

Initial: _____

Cancellation Policy

We understand there are times when you must miss an appointment due to emergencies or obligations to work and family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting a much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a treatment, due to a seemingly "full" appointment book.

Please contact our office if you cannot keep your scheduled appointment. Failure to notify us of your cancellation will result in a **$50.00 fee** payable prior to your next appointment.

Initial:_____

DME Waiver

I understand that Advantage Physical Therapy Corporation is NOT a certified Durable Medical Equipment Provider. I agree to be responsible for the charges associated with the dispensing of any accessory medical equipment at the time of service. I accept responsibility for submitting the claims for said supplies personally.

I further understand that if the reimbursement for the aforementioned supplies from my insurance company is less than the totals paid to Advantage Physical Therapy, there will be no reimbursement for the difference in cost.

Initial:_____

Notice of Privacy Practices (HIPAA Acknowledgement/Consent)

I hereby acknowledge that I have received a copy of The Notice of Privacy Practices for Advantage Physical Therapy.

In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operations.

Initial: _____

Payment Guarantee/Assignment of Benefits

Advantage Physical Therapy, as a courtesy, will verify your coverage and bill your insurance company. However, you are ultimately responsible for payment of your bill. You are responsible for payment of any deductible and co-payments/co-insurance as determined by your contract with your insurance carrier. We expect these payments at the time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, of if you or your physician elect to continue therapy past the approved period, you will be responsible for your account balance in full.
I agree to pay Advantage Physical Therapy Corporation, its subsidiaries and/or affiliates for the services provided to me or the party named above. If any law, such as workers' compensation, or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances. The Benefit Verification form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment for services.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of Advantage Physical Therapy Corporation and/or its affiliates or subsidiaries.

Initial _____

Patient/Guardian Signature_____Date_____

Past Medical History

Patient Name_____ Date of Birth_____Age_____

Reason for Therapy_____ Date of Onset/Injury_____

Have you had any surgeries related to your injury/condition? Yes No If so, please list the procedure(s) and the date of the procedure(s).

_____
_____
_____

Are you currently receiving treatment for the above condition? Yes No If so please describe below.

_____

Have you received therapy or treatment for the above condition in the past? Yes No If so, please describe. _____

Was this treatment successful? Yes No

Have you received physical therapy for any other conditions in this calendar year? Yes No

Are you or could you be pregnant? Yes No

Do you have any allergies? Yes No

If so, please list. _____
_____
_____

Are you currently taking any prescription or over the counter medications? If so, please list.

_____
_____
_____
_____

How would you classify your general health at this time? (circle one)

Excellent Very Good Good Fair Poor

Are you currently, or have you ever had or been diagnosed with any of the following conditions?

	YES	NO		YES	NO
Arthritis			Diabetes		
Osteoporosis			Anemia		
High Blood Pressure			Sensitivity to heat/cold		
Heart Disease			Swelling in legs		
Heart Attack			DVT		
Pacemaker			Metal implants		
Vascular Disease			Cancer/tumor		
Stroke			Recent weight loss		
Asthma			Recent weight gain		
Shortness of Breath			Fatigue/weakness		
Chronic Cough			Chronic Infection		
Dizziness			Tuberculosis		
Fainting spells			Hepatitis		
Nausea/Vomiting			Numbness/Tingling		
Previous Fractures			Fever/Chills		
Previous Surgeries			Thyroid problems		
Hearing Loss			Seizures/epilepsy		
Depression			Headaches		
Anxiety			Concussion		
Substance Abuse			Hernia		
High Cholesterol			Kidney Problems		

If you answered yes to any of the previous conditions, please give a brief explanation and approximate timing._____
_____
_____
_____

This information is, to the best of my knowledge, accurate and complete.

_____ _____

Patient/Guardian Signature Date