REGISTRATION

Date_____ **Home Phone #:**_____
Cell Phone #: _____

Patient_____
Last Name **First Name** **Initial**

Street Address_____
City_____**State**_____**Zip**_____
E-mail Address_____
Sex •M•F Age_____ **DOB:**_____**•Single •Married •Widowed •Separated•Divorced**
Social Security #_____
Health Insurance Company_____**Policy ID Number**_____
Policy Holder's Name_____
Relationship to Policy Holder •Self •Spouse •Child •Other
How would you like to receive appointment reminders •Text •Voice

PATIENT'S EMPLOYER	Company Name _____Occupation_____ Address_____Phone_____ City_____State_____Zip_____
POLICY HOLDER (If different from patient)	Name_____ Last Name First Name Initial Birthdate_____Social Security #_____ Employer Name_____Occupation_____ Address _____Phone_____ City _____State_____Zip_____
PATIENT INSURANCE AND LEGAL INFORMATION (Auto/Worker's Comp)	**If motor vehicle accident, please provide automobile insurance declarations page.** If Motor Vehicle Accident or Worker's Compensation Date of Accident_____ Insurance Company Name _____Adjuster_____ Address/Phone_____Claim #_____ Policy #_____Effective Date_____ Attorney Name:_____ Address/Phone:_____
EMERGENCY CONTACT INFORMATION	Person to contact in an emergency_____Home#_____ Cell#_____
PATIENT AGREEMENT	ASSIGNMENT AND RELEASE I, the undersigned, have insurance coverage with _____and Name of insurance company assign directly to **Prolete Physical Therapy and Sports Medicine, P.C.** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize **Prolete Physical Therapy & Sports Medicine, P.C.** to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. 1._____ _____ Signature of Insured/Guardian Date 2._____ _____ Signature of Insured/Guardian Date 3._____ _____ Signature of Insured/Guardian Date

PROLETE PHYSICAL THERAPY AND SPORTS MEDICINE P.C.

PHYSICAL MEDICINE AND REHABILITATION MEDICAL HISTORY

NAME:_____ DATE:_____

Referred by_____

OCCUPATION:_____

Condition Related to □Illness □Employment □Auto □Other

1. Present Complaint_____

   What are your present symptoms and when did they start?

   _____
   _____
   _____
   _____

2. Do you have? Pain □ Yes □No Tingling □ Yes □No Numbness □ Yes □No

   On a scale of 1 – 10 with 10 being excruciating pain, how would you rate your pain? (Circle one)

   1 2 3 4 5 6 7 8 9 10

3. How would you describe it?

   Sharp□ Dull□ Throbbing□ Burning□ Aching □ Constant □ Intermittent □ Other□_____

   _____

4. What makes your pain better? _____

   What makes your pain worse? _____

5. Are you currently taking any medications? □ Yes □No
   If yes, please list _____

6. Are you allergic to any medication or chemicals? □ Yes □No
   If yes, please list_____

7. Have you recently had an x-ray or other diagnostic test? □ Yes □No
   If yes, please list tests and where they were done

   _____
   _____

8. What kind of surgeries have you had? (please list)

   _____
   _____

9. Do you have any other known medical conditions we should be aware of? (Diabetes, heart problems, pacemaker, etc.?)

   _____
   _____

10. Have you received physical therapy before? □ Yes □No (If yes)
    When_____Where_____

11. Are you pregnant? □Yes □No Not Applicable □ Do you have a pacemaker □ Yes □No

12. Any other comments/ problems? _____

PROLETE PHYSICAL THERAPY AND SPORTS MEDICINE, P.C.

Consent for Use or Disclosure of Health Information

The effective date of this privacy notice is April 14, 2003

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before your sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

_____	_____
Printed Name	Authorized Provider Representative
_____	_____
Signature	Date
_____	
Date	

PROLETE
PHYSICAL THERAPY & SPORTS MEDICINE OF MILFORD
247 Broad Street Suite 3
Milford, CT 06460
Tel: 203-693-3754
Fax: 203-283-3908

Physical Therapy Patient Agreement

Chief complaint:

_____

I, _____, have elected to see a physical therapist without a referral from a physician, as eligible by Connecticut State Law. I give Prolete Physical Therapy and Sports Medicine, P.C. permission to provide my Primary Care Physician a copy of my physical therapy evaluation. I understand that if my underlying medical condition is prolonged, and does not improve in a 30 day period or 6 treatment sessions (whichever is earlier), or continues to require ongoing continuous treatment, then my physical therapist is required by law to consult with/refer me to my primary care physician or health care provider of record before I can continue with further care. I would like to designate the physician to be consulted regarding my care to be:

_____

Primary Care Physician Name

_____

_____

Physician Address

Patient Signature: _____ Date: _____

Prolete Physical Therapy & Sports Medicine, P.C.