First Health Physical Therapy **PATIENT REGISTRATION**

I. Personal Information

Date ____________ Name (Last, First) ____________

Birthdate ____________ Gender: Male ☐ Female ☐

Marital Status Single ☐ Married ☐ Other ☐

Address ____________ Apt #______ City ____________ State _____ Zip _____

Phone Number____________ Cell____________ Email____________

Emergency Contact ____________ Relationship ____________

Home Phone ____________ Work Phone ____________ Extension ____________

Referred By ____________

II. Guarantor / Policy Holder

Name ____________ Phone ____________

Address ____________ City ____________ State ____________ Zip ____________

III. Insurance and Payment

Insurance Company ____________ Insurance Phone Number ____________

Fee $______/ per visit Insurance will cover ______ % Patient responsibility ____________

Deductible per year $ ________ $ ________ has been met Out of pocket $ ________ $ ________ has been met

IV. Practice Policy & Patient Signature

Cancellations: Your appointment time is exclusively for you. It is for this reason that we request you give us **a minimum** of **24 hours notice** when canceling or you will be charged for the appointment. **The cancellation fee is $125.00.**

Confidentiality: NOTICE OF PRIVACY AND PRACTICES As required by the Privacy Regulations of the Health Insurance Portability and Accountability Act (HIPAA) EFFECTIVE DATE: APRIL 14, 2003

This office adheres to all rules regarding the confidentiality of patient records. Employees have access only to patient information necessary to properly perform the function of their jobs. This office will communicate with the patient's insurance companies and other health care practitioner(s) by letter, phone, or fax upon written permission from the patient. Only information necessary to process claims is released to insurance companies.

Patient Acknowledgement and Consent:

1. I have been informed of the regulations regarding the Patient Health Information Notice of Privacy and Practices by First Health Physical Therapy.
2. I further authorize First Health Physical Therapy to release to the appropriate agencies, any information acquired in the course of my, or the above named patient's, examination and treatment.
3. If assignment is accepted, I authorize and request my insurance companies to pay directly to First Health Physical Therapy benefits otherwise payable to me. **I understand that accepting assignment is a courtesy extended to me by this office and that I am financially responsible for any coinsurance, deductibles, and services that are not covered or deemed "not medically necessary" by my insurance companies.** Further, I understand that if an insurance claims **if not paid within 45 days, I am responsible for the full amount immediately.**
4. If assignment is not accepted, I understand that I am financially responsible for all services and payment is due at each visit unless other arrangements have been made.
5. If First Health Physical Therapy is a participating provider with my insurance companies, I understand that I am subject to the terms and conditions of my insurance policy.
6. I have read and understand the cancellation policy.
7. I authorize the release of any medical information necessary to process all claims, and I authorize First Health Physical Therapy to communicate with my insurance companies and other health care practitioner(s) as necessary by letter, phone, or fax.
8. I hereby authorize First Health Physical Therapy through its appropriate personnel to perform, or have performed upon me, or the above named patient appropriate assessment and treatment procedures relating to the diagnosis stated by my referring physician.
9. I have read the above information regarding my insurance policy. I certify that the information above, to the best of my knowledge, is true and accurate. I authorize my insurance carrier to pay First Health Physical Therapy directly for services provided. I agree to pay First Health Physical Therapy the entire amount of bills incurred for physical therapy services provided not covered by my insurance carrier.

Signature ____________________________ Date ____________

FIRST HEALTH PHYSICAL THERAPY

Medical History Form

1. Please mark the appropriate boxes that apply to your medical history:

☐ Diabetes ☐ Hypertension ☐ Cancer ☐ Heart Disease ☐ Stroke
☐ Asthma ☐ Heart Attack ☐ Emphysema ☐ Tuberculosis ☐ Angina
☐ Hepatitis ☐ Osteoarthritis ☐ Pacemaker ☐ Epilepsy ☐ Pregnant
☐ Allergies ☐ Alcohol abuse ☐ Depression ☐ Tobacco Use ☐ Drug Abuse
☐ Cardiovascular Disease ☐ Rheumatoid Arthritis

2. Please list any other diseases or conditions not mentioned:

3. Please list any previous surgeries:

4. Please list any medications you are currently taking and specify dosage:

5. What is your goal for therapy?

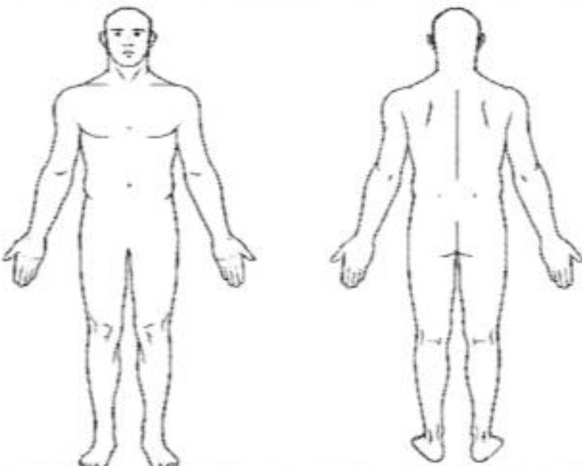
6. Please rate your pain at best: (0 = None) 0 1 2 3 4 5 6 7 8 9 10 (10 = Unbearable)

7. Please rate your pain at worst: (0 = None) 0 1 2 3 4 5 6 7 8 9 10 (10 = Unbearable)

8. Please circle the items that best describe your pain:

Sharp **Shooting** **Radiating** **Twinge** **Dull/Ache** **Throbbing** **Numbness** **Tingling** **Burning**

9. Please mark on the diagram where your pain is located:



10. Height ____ ft ____ in

11. Weight _____ lbs

12. Blood pressure: _______ systolic

_______ diastolic

SIGNATURE: ___________________________