ADAPT PHYSICAL THERAPY

Patient Registration

Last Name | **First Name** | **MI** | **Nickname**

Mailing Address | **City** | **State** | **Zip**

Home Phone | **Cell Phone** | **Work Phone**

Date Of Birth | **Social Security Number** | **E-Mail**

Employer | **Address** | **Employer Phone**

Spouse Name | **Spouse Employer** | **Phone #**

Emergency Contact | **Phone Number**

Have you had Physical Therapy this year at any other location?_____ If yes, how many visits?_____

How did you hear about us? ___ Physician Office ___ Phone Book ___ Newspaper

___ Facebook ___ Insurance Co ___ Family/ Friend_____
(Please tell us who so we can thank them)

If Under Age 18, please complete the following:

Name of Parent or Guardian | **Social Security Number** | **Date of Birth**

Mailing Address | **City** | **State** | **Zip**

Phone Number | **Work Phone**

Employer | **Address** | **Employer Phone**

Insurance Information:

Insurance Company | **Policy Number** | **Group Number**

Address | **City** | **State** | **Zip Code** | **Phone Number**

Work Injury/ Motor Vehicle Accident Information:

Is today's visit a result of an injury or accident ___No ___ Yes If yes (please circle) WORK AUTO OTHER

Accident Insurance Company | **Adjuster Name** | **Adjuster Phone Number**

Claim Number | **Insurance Co Address** | **State** | **City** | **Zip Code**

Patient Condition

Reason for visit:_____

When did your symptoms appear?_____

Is this condition getting progressively worse? __ Yes __ No __ Unknown

Are you having trouble sleeping? __Yes __ No

Normal Hours of sleep ___ Current hours of sleep ___

Have you had any treatment for your current condition?
(Check all that apply)

☐ Hospitalization ☐ Bracing/ Taping/ Casting ☐ Physical Therapy

☐ Surgery ☐ TENS/ Stimulation Unit ☐ Injections ☐ Chiropractic

☐ Acupuncture ☐ OTHER _____

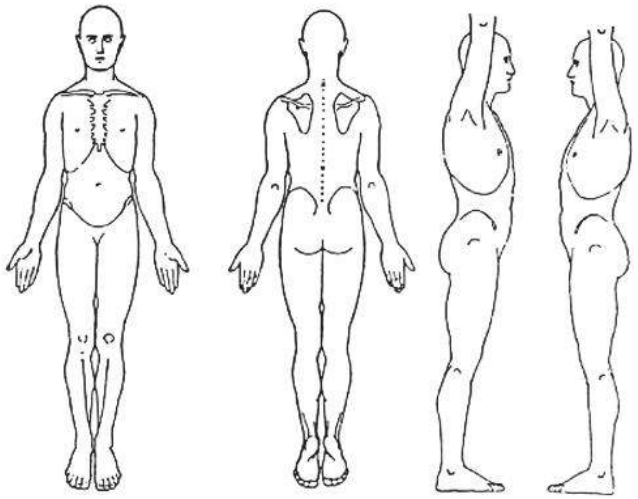
Before the onset of my current symptoms (or prior to injury) I was:

☐ Independent in all activities ☐ Independent with self-care only

☐ Needing assistance with some activities ☐ Needing assistance with most activities

☐ Dependant for all care

Mark an X on the picture where you continue to have pain, numbness or tingling



Please mark your level of pain at rest

No Pain Worst Pain Imaginable

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Please mark your level of pain with activity

No Pain Worst Pain Imaginable

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 - 10

Health History

☐ Heart Problems
☐ Fainting or dizziness
☐ Shortness of breath
☐ Calf pain with exercise
☐ Severe headaches
☐ Recent Accident
☐ Head trauma/ Concussion
☐ Muscular weakness
☐ Cancer:_____
☐ Joint dislocation
☐ Broken bones
☐ Difficulty sleeping
☐ High blood pressure
☐ Mouth numbness
☐ Kidney disease
☐ Liver disease
☐ Weakness or fatigue
☐ Bowel/ bladder problems
☐ Balance problems/ Vertigo
☐ Swollen ankles or legs
☐ Tremors
☐ Night pain while sleeping
☐ Unexplained weight loss
☐ Pregnancy
☐ Difficulty swallowing
☐ A wound that does not heal
☐ Unusual skin condition
☐ Lung disease/ problems
☐ Arthritis
☐ Swollen/ painful joints
☐ Irregular Heartbeat
☐ Stomach pain or ulcer
☐ Back or neck injuries
☐ Pain with cough or sneeze
☐ Stroke
☐ Muscular pain with activity
☐ Frequent falls
☐ Chest Pain or pressure at night
☐ Epilepsy/ seizures/ convulsions
☐ Constant pain unrelieved with rest
☐ Nervous or emotional problems
☐ Diabetes: Type ___
☐ Hernia
☐ Blurred visions
☐ Circulatory problems
☐ Jaw problems
☐ Any infectious disease _____
☐ OTHER _____

HABITS

Smoking **Packs/ day_____**

Alcohol **Drinks/ week____**

Coffee/ Caffiene drinks **Cups/ Day___**

High Stress Level **Reason_____**

ALLERGIES

PRIOR SURGERIES

MEDICATIONS

WORK ACTIVITY

☐ Employed ☐ Employed with restrictions

☐ On Medical Leave

☐ Not employed ☐ Retired

EXERCISE

Type _____ Times/ week_____

CONSENT TO PHYSICAL THERAPY TREATMENT/AUTHORIZATION TO PAY/RELEASE OF INFORMATION:

I authorize ADAPT Physical Therapy to render treatment, as it/ they determine necessary, to me/ my dependant. I understand that I will be given all pertinent information prior to the treatment being rendered. I will be given the opportunity to ask questions and to have them answered. I understand I may decline treatment at any time.

I authorize ADAPT Physical Therapy to bill my health insurance for services rendered. All payments received will be applied to my balance. I will be responsible for all co-pays/ coinsurance and deductibles that may apply. I understand that ADAPT Physical Therapy will bill my insurance as a courtesy to me but not as an obligation. Although ADAPT Physical Therapy will help to verify and assist in understanding my benefits, it is ultimately my responsibility and I will not hold ADAPT Physical Therapy responsible for any misunderstanding or misinterpretation of insurance benefits. I understand that any charges not paid by my insurance company are due and payable by me.

MEDICARE PATIENTS ONLY – I authorize payment of Medicare benefits to ADAPT Physical Therapy for services rendered and I authorize release of medical information to the Centers for Medicare and Medicaid Services.

I have been given the Notice of Patient's Rights and I consent to Physical Therapy treatment. A photocopy of this signed document shall be considered as valid as the original.

_____ _____

Signature **Date** **Patient or Parent/Guardian** **Date**

Designated Individuals Authorization

Please list below any spouse, parent, child, etc that ADAPT Physical Therapy may release your confidential medical record/ information and/ or financial account information pertaining to this office. In addition, in the event that we are unable to reach you directly, by phone, and you would like to request that your protected health information be left on a personal voice message system(s), please indicate below the number(s) that provide the access to the voice message system that we may leave a detailed message on.

In signing this agreement, I hereby authorize the staff at ADAPT Physical Therapy to release any protected health information regarding my treatment, payment or administrative operations related to treatment and payment for services received at ADAPT Physical Therapy to one or all of the designated parties listed below. I understand it is my responsibility to update this list as I deem necessary and that the identity of the designated parties must be verified before the release of any information.

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Patient Signature_____ Date:_____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I understand that Aaron D Anders Physical Therapy Inc. will use and disclose health information about me in the course of providing physical therapy care to me.

I understand that my health information may include information both created and received by the clinic, may be in the form of written or electronic records or spoken works, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar health-related information.

I understand that the clinic is permitted to use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to/or consult and coordinate with other health care providers in the course of my treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business functions that support the clinic's ability to provide me with appropriate care, including provision of medical supplies and equipment and, and arrange for payment.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request and that a copy or a summary of the most current version of the clinic's Notice of Privacy Practices in effect will be posted in the waiting/reception area.

I understand that the Notice of Privacy Practices describes how I can exercise my right to ask that some or all of my health information not be used or disclosed, and I understand that the clinic is not required to by law to agree to such requests.

By signing below, I agree that at any time I may have a copy of this clinic's Notice of Privacy Practices.

By: _____ Date: _____

Patient

-OR-

By: _____ Date: _____

Patient Representative

Description of Representative's Authority: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❒ Individual refused to sign
- ❒ Communication barriers prohibited obtaining the acknowledgement
- ❒ An emergency situation prevented us from obtaining acknowledgement
- ❒ Other (Please Specify)