Patient Registration

First Name: _____ Last Name: _____

Preferred Name: _____ Date of Birth: _____

Email: _____ SSN: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer/School: _____ Position: _____

Marital Status: Married Single Divorced Widowed Pronouns: _____

Insurance Information

Primary Insurance Name: _____ Primary Insurance Policy Number:_____

Secondary Insurance Name: _____ Secondary Insurance Policy Number: _____

In case of an emergency, whom shall we contact?

Name: _____ Relationship: _____

Primary Phone: _____ Secondary Phone: _____

Designated Individuals Authorization

Please list below the name and relationship of anyone that we may release your confidential medical, personal or financial information pertaining to this office.

By 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 my treatment at Adapt Physical Therapy to one or all of the designated parties below. I understand it is my responsibility to update the list as necessary and that the identity of the designated parties must be verified before the release of any information.

Name: _____ **Relationship**: _____

Name: _____ **Relationship**: _____

I acknowledge that the information above is correct to the best of my knowledge and the signature below allows Adapt Physical Therapy to share my personal, health and financial information only to the people that I have listed above which I can rescind permission at any time in writing.

Signature: _____ **Date: _____**

Insurance Information

Is today's visit a result of an work or motor vehicle injury? (please circle) YES NO

If yes please list claim information below.

Who would you like us to bill for services? Self Insurance

Work Injury/ Motor Vehicle Accident Information (please circle) Work Auto

Insurance Carrier:_____ Date of Injury/Accident:_____

Adjuster Name:_____ Phone number:_____

Consent to Bill and Treat for Physical Therapy Services

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

I authorize Adapt Physical Therapy to bill my insurance if applicable for any rendered services provided. I understand that a co-pay, co-insurance, or deductible payment may be required at the time of service. I understand that I am financially responsible for any services provided by Adapt Physical Therapy and will make appropriate payments or payment arrangements at the time of receiving a billing statement.

I acknowledge that the information and consent I have given is correct to the best of my knowledge and this signature allows Adapt Physical Therapy to use the information as needed for treatment and billing purposes.

Printed Name:_____ **Date:**_____

Signature:_____

Acknowledgment of Notice of Privacy Practices

I understand that ADAPT Physical Therapy (referred to below as "clinic") will use and disclose health information about me in the course of providing physical therapy care for me.

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 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 services
- Perform various office, administrative and business functions that support the clinic's ability to provide me with appropriate care and arrange for payment

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

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 to be used or disclosed, and I understand that the clinic is not required by law to agree to such requests.

Request for Electronic Communications

I request that the following communications from the clinic be delivered to me by the provided electronic means. I understand that this form of communication may not be secure, creating a risk of improper disclosure to unauthorized individuals. I am willing to accept that risk, and will not hold the clinic responsible should such an incident occur.

Communications

____Appointment Reminders _____Billing

Method

_____Email _____Text

Email Address_____ Phone Number_____

By signing below, I agree that I have received or been offered a copy of the clinic's Privacy Practices and agree to the forms of communication above.

Patient: _____ **Date**: _____

Patient Representative: _____

Pre-Exam

Patient Name: _____ Date: _____

1. Are you working currently? Yes No If yes, occupation: _____
2. Have you had Physical Therapy or Chiropractic this year? _____
3. If yes, how many visits_____
4. Where is your pain/problem? _____
5. What caused your pain/problem? _____
6. Approximately what date did it start _____
7. Is it getting worse, better or staying the same?_____
8. Have you had this problem before?
9. If yes, how many times has it occurred in the last three years?_____
10. On a scale of 1 to 10, what is your worst level of pain in the past week?

    1 2 3 4 5 6 7 8 9 10

    Mild Moderate Severe

11. Have you had any surgeries related to this problem? (please included dates):
12. Do you have a Pacemaker? 13. Are you currently pregnant?

Health History (please circle any conditions that apply)

High Blood Pressure	Alzheimer's	Huntington's	Parkinson's
Cardiovascular Disease	Immuno-suppression	Lupus	Muscular Distrophy
Obesity	Traumatic Brain Injury	Osteoarthritis	History of Cancer
Major Motor Weakness	Saddle Anesthesia	Cauda Equina Syndrome	
Diabetes Type 1	Diabetes Type 2		

Patient/Parent/Guardian Signature: _____Date:_____

Patient Name **DOB :**

Allergies

Please list all allergies and reactions:

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Medications

Please list all medications and frequency:

1.
2.
3.
4.
5.
6.
7.
8.
9.