PHYSICAL THERAPY SOUTH, INC.

Patient Registration Form

Personal Information

Last Name:_____ First:_____ MI:_____

Home Address:_____Apt#:_____

City:_____State:_____Zip Code:_____

Mailing Address:_____

City:_____State:_____Zip Code:_____

Injury/Illness:_____Home Phone:_____

Date of Injury/Onset of symptoms:_____Work Phone:_____

Date of Birth:_____/_____/_____Age:_____Cell Phone:_____

Patient SSN (For Insurance Benefit Verification):_____

Email Adress:_____

Emergency Contact:_____Relationship:_____

Emergency Contact Phone:_____

Referring Physician Name:_____

City/State:_____

Employer Name:_____

Address:_____City:_____State:_____

Primary Insurance Information

Is this an auto accident?: □ Yes □ No Is this a work related injury?: □ Yes □ No

If "Yes", list claim # and adjustor contact information below:

Claim Number:_____

Adjustor Name:_____

Adjustor Phone:_____Ext.:_____

Health Insurance Company Name:_____

Subscriber's Name:_____ Subscriber DOB:____/____/____

Relationship to Subscriber_____ Subscriber SSN:_____

Policy Number:_____ Group Nuber:_____

Secondary Insurance Information

Health Insurance Company Name:_____

Subscriber's Name:_____ Subscriber DOB:____/____/____

Relationship to Subscriber_____ Subscriber SSN:_____

Policy Number:_____ Group Number:_____

Consent to Treatment

I hereby authorize the professional staff at PHYSICAL THERAPY SOUTH, INC. to examine and treat me with physical therapy for the injury/illness I have been referred here for or referred myself to.

_____

Patient Signature Printed Name Date

_____

Parent or Guardian Signature (if under 18) Printed Name Date

Assignment and Instruction for Direct Payment to Health Provider

Insurance Company/Companies Name(s):_____

I hereby instruct the above named insurance company/companies to pay by check/virtual credit card made out to and mailed directly to: ***PHYSICAL THERAPY SOUTH, INC.*** for professional/medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for services rendered.
THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.
This payment will not exceed my indebtedness to the above mentioned assignee and I agree to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment as required by my insurance policy.

_____

Patient Signature Printed Name Date

_____

Parent or Guardian Signature (if under 18) Printed Name Date

Notice of Privacy Practices

I hereby authorize that I am aware of my rights as it pertains to HIPAA and my Protected Health Information (PHI). PHYSICAL THERAPY SOUTH, INC. has offered me a copy of their Notice of Privacy Practices for my own records.

If there is anyone you would like to authorize the disclosure of your PHI, medical or billing, you may specifically name the party below and indicate what information you would like disclosed:

1._____ Disclose:_____

2._____ Discolse:_____

_____

Patient Signature Printed Name Date

_____

Parent or Guardian Signature (if under 18) Printed Name Date

Staff Witness Initials:_____ **Date:**_____

Medical History Information Sheet

1. What would you say is the pain rating for your current condition using a scale of 0 – 10? (0 = no pain, 10 = worst pain imaginable) _____

2. Do you now or have you ever had the following?		Explanation
Stroke	yes_____no_____	_____
Heart Disease or Heart Murmur	yes_____no_____	_____
High Blood Pressure	yes_____no_____	_____
Asthma	yes_____no_____	_____
Diabetes	yes_____no_____	_____
Epilepsy/Fainting	yes_____no_____	_____
Impairment of Vision or Hearing	yes_____no_____	_____
Cancer	yes_____no_____	_____
Drug Allergies	yes_____no_____	_____
Osteoporosis	yes_____no_____	_____

Orthopaedic History – Please give dates & treatments received:

3. Have you ever sprained, strained, dislocated or fractured the following:

Neck/Head (including concussion)_____

Trunk (ribs, vertebrae, sternum) _____

Low Back (vertebrae, discs, nerves)_____

Upper Extremity (shoulder, elbow, wrist, arm)_____

Lower Extremity (hip, leg, knee, ankle, foot)_____

4. Please list any surgeries that you have had and their dates:_____

_____

5. Please list medication(s) presently taking:_____

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6. Circle One: Male / Female Women: Are you pregnant: yes_____ no_____

7. Have you ever had physical therapy in the past? yes_____ no_____
   If yes, when?_____

8. **IF YOU HAVE MEDICARE, HAVE YOU EVER HAD HOME HEALTH CARE?**_____
   If yes, what is the name of the agency?_____

I agree that the above information accurately describes my medical history and that should any changes in my medical history occur, I will notify my PT immediately.

_____

Patient/Guardian Signature Print Name Date

PHYSICAL THERAPY SOUTH, INC.

Missed Appointment Policy

We strive to provide our patients with excellent service and quality care. Our commitment to your well-being and health is something that we at *Physical Therapy South* take very seriously.

Your commitment to your physical therapy program is critical to your success. We will recommend treatment and set goals for you. In order to reach those goals you must do your part and your most important part is to make each and every appointment.

We will give you an appointment card to keep track of your appointments. If you should misplace this, please give us a call to review your appointment dates. We expect you to keep all your appointments; however should you need to cancel please not that we require a **24-hour notice.**

If you need to cancel, please call our office reschedule. If you do not cancel with a 24-hour notice or if you do not show for an appointment **you will be charged $25** for the missed appointment.

If you miss 3 consecutive appointments, *Physical Therapy South* reserves the right to notify your physician and require a new referral in order to continue treatment.

We thank you for choosing *Physical Therapy South* and we are looking forward to working with you and helping you reach your goals.

I have read and understand the "Missed Appointment Policy."

Patient/Guardian Signature Name Printed Date