Back In Form Physical Therapy Registration Forms

Patient Full Name:_____

Date of Birth:_____ Referring Physician:_____

Gender: Male_____ Female_____ Occupation:_____

Home Address:_____

Email Address:_____ Home Phone:_____

Cell Phone:_____ Emergency Contact:_____

Can we share information with this person, including care and payment information?

Yes_____ No_____

Are you receiving home health? Yes_____ No_____ Why did you choose our facility? _____

Chief Complaint:_____

Are you presently working? Yes_____ No_____ Is the injury work related? Yes_____ No_____

If yes, date of the injury? _____

Was your injury a result of a motor vehicle accident? Yes_____ No_____

Is an attorney involved? Yes_____ No_____

Have you, for any reason, received outpatient physical therapy this calendar year? Yes_____ No____

If yes, approximately how many visits?_____

I authorize the office of, Back In Form Physical Therapy Inc., to file my insurance claim and receive payments for services rendered. I understand that I am responsible for any co-pays, deductibles, or percentages that my insurance does not cover. Due to federal kickback laws, we are legally prohibited from writing off deductibles, patient co-insurance as directed by your insurance carrier, or co-payments. If your insurance policy pays the patient instead of the provider, we will need to collect payment at the time of service. I understand that if I do not have insurance coverage, payment is due at time of service unless other arrangements are made with this office. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information. **I understand that Medicare will not pay for physical therapy services if I am currently receiving home health care.**

Patient/Guardian Signature:_____ Date:_____

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Have you had any of the following tests for THIS condition? If so, date?_____

X-Ray_____ MRI_____ CT Scan_____ EMG_____ Other_____

Please list any surgeries (in/outpatient) and hospital stays and the corresponding dates:

_____

_____

During the past month, have you been feeling down, depressed, or hopeless? Yes_____ No_____

During the past month, have you been bothered by having little interest or pleasure in doing things?

Yes_____ No_____

Are you currently being treated by a physician for any heart related disorder? Yes_____ No_____

If yes, what was the diagnosis?_____

Have you had a fall in the last year? Yes_____ No_____

If yes, how many and were you injured? Please describe:_____

_____

Please list any prescription/over-the-counter medications you are currently taking (including vitamins):

_____

_____

Have you been diagnosed with having any of the following conditions? Check all that apply.

Seizures/Epilepsy_____ Cancer_____ Diabetes_____ Vision/Hearing Issues_____ Headaches_____

Osteoporosis_____ Strokes/TIAs_____ High Blood Pressure_____ Pacemaker_____ Anemia_____

Heart Problems_____ Rheumatoid Arthritis_____ Hepatitis_____ Alzheimer's/Dementia_____

Circulation Problems_____ Depression/Anxiety_____ Asthma_____ Thyroid Disorder_____

Emphysema/COPD_____ Parkinson's Disease_____ Multiple Sclerosis_____ Incontinence_____

Please list any not listed above:_____

Have you recently noted any of the following?

Weight Loss/Gain_____ Weakness_____ Nausea/Vomitting_____ Fever/chills/sweats_____

Dizziness/Lightheadedness_____ Numbness/Tingling_____ Fatigue_____ Night Pain_____

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Please indicate your goals for physical therapy:_____

_____

Pain Scale - Please rank your pain on a scale from 0-10: 0 being pain free, 10 needing a hospital

0____1____ 2____ 3____ 4____ 5____ 6____ 7____ 8____ 9____ 10____

Which of the following aggravates your pain? Check all that apply.

Sitting_____ Rising from seated_____ Standing_____ Lying down_____ Overhead Activity_____

Lifting_____ Bending_____ Walking_____ Running_____ Stairs_____ Squats_____ Dressing_____

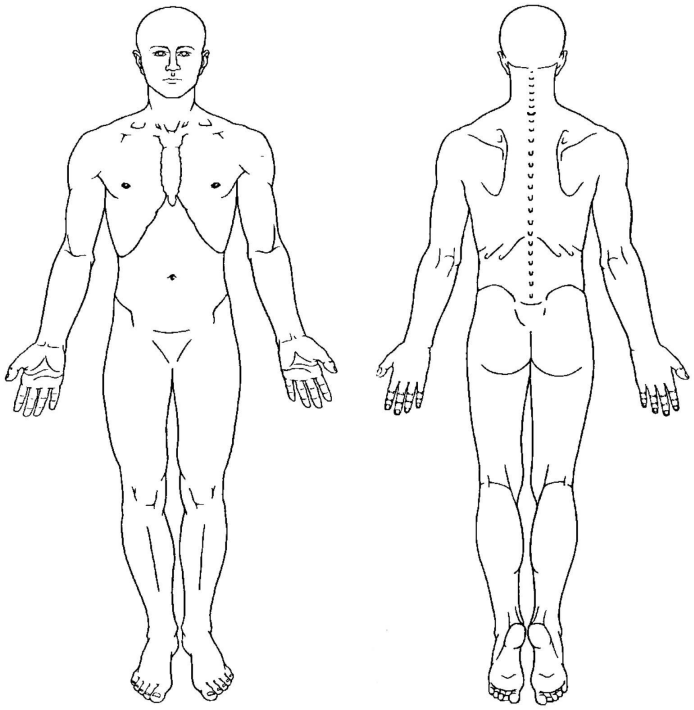
Stress_____ Coughing/sneezing_____ Looking over shoulder_____ Looking up/down_____

Other_____

What eases your pain? Rest_____ Ice_____ Heat_____ Changing Positions_____ Meds_____

Other_____

Please mark the corresponding pain areas on the diagram.



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Cancellation and No Show Policy

On your first visit to Back In Form Physical Therapy, your therapist will complete an evaluation. At the end of your evaluation, your therapist will explain the frequency and type of treatment you will receive. For example, clinical sessions 2-3x per week for 4 weeks with an independent exercise program. Physical therapy is an intense, yet brief, treatment program for maximum pain relief. The goal is to return to the highest level of function possible. Missing one or two of your recommended appointments in a week will not allow these goals to be met.

If you are unable to attend one of your appointments, kindly give us 24 hours notice. It is in your best interest to make up that missed appointment. **Effective 10/01/2023, if you do not call to cancel within 24 hours or fail to show, you will incur a $75.00 cancellation/no show fee**.

If you miss 3 scheduled appointments, a notice will be sent to your referring physician informing him/her that the treatment plan has not been adhered to. It is the therapist's discretion to continue treatment or discharge you from therapy. We will always take into consideration illness, hospitalization, family emergencies, and uncontrollable circumstances.

If you are going to be late for an appointment, please notify us so that we can adjust our schedule accordingly. Please understand that we will try to administer your full treatment, however, time restraints may limit this. **Failure to arrive within 15 minutes of the scheduled appointment will result in a $50 late fee and possible rescheduling of the appointment.**

It is our desire to work with you and your physician to address your needs and goals in the most effective way possible. We greatly appreciate your cooperation and look forward to helping you achieve a better quality of life. If you have any questions, please feel free to ask any of the staff.

Patient Signature:_____ Date:_____

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Privacy and Assignment of Benefits

Informed Consent - I understand as a patient of Back In Form Physical Therapy the following:

- I have the right to receive complete and current information regarding my diagnosis, treatment, and any known prognosis. This information will be communicated to me in terms I can understand by my therapist.
- I have the right to accept medical care or refuse treatment to the extent permitted by law, and to be informed of the medical consequences, if I refuse treatment. I understand that if I refuse recommended treatment, Back In Form has the right to discharge me from therapy.
- I will be informed if Back In Form wishes to participate in or perform any research or educational projects that would affect my care. I understand that I have the right to choose whether I participate. I will receive the most effective care the clinic can provide.
- Patient's Rights will be posted in a prominent location for my review and I can discuss any questions with my therapist.

Privacy Policy - I understand there is a copy of Back In Form Physical Therapy Privacy Practices posted and it is my right to request a copy. I also understand that as part of treatment, payment, or health care operations, it may become necessary to disclose my health information to another entity (doctor, insurance provider, case manager, etc) and I consent to such disclosure for these permitted uses, including via fax.

Auto Accidents - If your health problem is the result of an auto accident, you must provide us with your auto insurance and major medical policy information. We will file with your auto carrier if you have opened a med pay claim, otherwise, we will file with your medical insurance. We do not file with third party payors. You have the option to self-pay should you choose not to file with your med pay or medical insurance.

Assignment of Benefits - I hereby assign all benefits directly to Back In Form Physical Therapy and also authorize release of any medical records necessary to process medical claims. I understand fully that in the event my insurance company or financially responsible party does not pay for the services, I will be financially responsible for payment.

Patient Signature:_____ Date:_____

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Appointment Reminder Consent

Please complete this form and sign below to give Back In Form Physical Therapy permission to provide automatic appointment reminder service by email or text message.

Choose one option:

Send email messages to:_____

Send text messages to:_____

If you would like text messages instead of email reminders, please indicate your cell phone carrier. We cannot set up your reminders without this information.

ALLTel_____ AT&T_____ Boost Mobile_____ Cingular_____ Cricket Wireless_____ Metrocall_____ MetroPCS_____ Nextel_____ Qwest_____ Sprint_____ T-Mobile_____ US Cellular_____ Verizon_____ Virgin Mobile_____ Xfinity_____

Patient Signature:_____ Date:_____

FOR THERAPIST USE ONLY

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