PHYSICAL REHABILITATION INSTITUTE – NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name _____ SS#_____
LAST FIRST MIDDLE

Birthdate _____ Marital Status _____ Sex _____ Phone _____

Address _____ City_____ State _____ Zip_____

Employment ❑ Full-time ❑ Part-time ❑ Unemployed ❑ Self Employed ❑ Retired (date) _____

Employer _____ Occupation _____

Address _____ City _____ State _____ Zip _____

Work Phone _____ Extension _____

PHYSICIAN / EMERGENCY CONTACT

Referring Physician _____

Primary Care / Family Physician _____

Emergency Contact Name _____ Relationship to Patient _____
LAST FIRST MIDDLE

Home Phone _____ Work Phone _____ Cell Phone _____

ACCIDENT INFORMATION

Is this due to an Auto Accident? ❑ Yes ❑ No

Auto Accident Date and Time _____ State the Accident Occurred _____

Auto Insurance Info _____ Phone _____

Auto Insurance Address _____ City _____ State _____ Zip _____

Is this due to a Work-related injury? ❑ Yes ❑ No Work Injury Date and Time _____

Case Manager/Adjustor Name _____ Phone _____

FOR MEDICARE BENEFICIARIES ONLY: PLEASE COMPLETE THE FOLLOWING SECTION

Is your Medicare based on: ❑ **Age** ❑ **Disability** ❑ **ESRD**	**YES**	**NO**
Are you currently receiving any Home Health services from anyone?		
Have you had Physical Therapy services this year?		
Do you have an active diagnosis of depression?		
Do you have a diagnosed Bipolar Disorder?		

PLEASE CIRCLE THE NUMBER THAT CORRESPONDS TO THE APPROPRIATE FREQUENCY

OVER THE LAST 2 WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY THE FOLLOWING PROBLEMS?	**Not at all**	**Several days**	**More than half the days**	**Nearly Every day**
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

--HEALTH INFORMATION

NAME: **DATE:**

INFORMATION ABOUT YOUR INJURY/PAIN

Complaint/Diagnosis _____ Onset Date _____

Have you ever been treated for this injury? ❑ Yes ❑ No If so, what kind? _____

Have you ever had Physical Therapy for this injury? ❑ Yes ❑ No

Have you had x-ray/MRI/other imaging study for this problem? ❑ Yes ❑ No Results: _____

_____

PAST MEDICAL HISTORY

Please check YES/NO if you presently have or have ever been diagnosed with any of the following:

	YES	NO			YES	NO
Pacemaker/Defibrillator				Osteoporosis		
Surgical Implants				Arthritis		
Cancer (currently or past 5yrs)				Rheumatoid Arthritis		
Latex allergy				Asthma/Chronic Bronchitis		
High blood pressure				Emphysema		
Seizures				Hepatitis		
Diabetes				Bowel/Bladder Problems		
Low blood sugar				Head/Neck Trauma		
Stroke				Feel faint or have spells of severe dizziness?		
Pregnant (currently)				Have you fallen in the past 6 months?		
HIV/AIDS				Do you smoke?		
Lung disease				Alcoholism		
Any heart problems				Drug Abuse		

Are you receiving any treatment for any other medical condition: _____

_____

PATIENT SUMMARY LIST

Significant Medical Diagnoses and Conditions: _____

_____

Significant Infections(C-Diff, MRSA, etc): ❑ Yes ❑ No _____

Please list all Previous Surgeries (with approximate date) :

_____

_____

Do you take blood thinners/aspirin? ❑ Yes ❑ No

❑ **See Attached Medication List**

Medications (including Prescriptions, Herbals and Over-the-Counters Drugs): Name, Dosage, Frequency and Route of Administration are all required

NAME	DOSAGE	FREQUENCY	ROUTE OF ADMINISTRATION

****PLEASE USE BACK OF PAPER IF NEED MORE ROOM TO LIST MEDICATION (REMEMBER NAME, DOSAGE, FREQUENCY, AND ROUTE)

– General Authorization and Attendance Policy Acknowledgement of Notice of Privacy Practices

Name: **Date:**

General Authorization

Assignment of Insurance Benefits:
In consideration of services rendered, I hereby transfer and assign all right to payment due to me for physical therapy services under any policies of insurance to Physical Rehabilitation Institute (PRI). As a courtesy, PRI will attempt to contact my insurance carrier for verification of my physical therapy benefits and will make every effort to discuss those benefits with the patient/responsible party in a timely manner. However, I understand that I am responsible for contacting my insurance carrier for determination of my physical therapy benefits and that I am responsible for payment of any services applied towards my co-payment, coinsurance, deductible and/or services not deemed medically necessary by my insurance
carrier.

Open Gym Atmosphere/Children:
I acknowledge that treatment may be provided in an open gym atmosphere. For the safety of our patients and your children, unattended small children are prohibited in the fitness/gym area and the reception area. PRI is not responsible for any lost or misplaced personal belongings.

Authorization for Treatment:
I hereby request and authorize all treatment from Physical Rehabilitation Institute and/or associated assistants of their choice and understand my responsibility for payment of this account regardless of insurance.

Returned Check Fee & Collection Fee:
There will be a $30 charge for any check returned for insufficient funds. In addition, in the event of default, for any reason, the patient will be responsible for any and all fees associated with the collection process.

Attendance Policy

Canceling Appointments

- If you must cancel an appointment, we ask that you please contact our office at least 24 hours in advance**. If you do not call 24 hours in advance, you may be subjected to a $30 cancellation fee**. You may leave a message on our confidential voice mail if it is not during regular business hours.
- If we must change or cancel an appointment time with you, we will give you as much advance notice as possible. We appreciate your cooperation.

Missed Appointments

- If you miss a scheduled visit, your therapist or a staff member will attempt to call and remind you of your next scheduled appointment.
- If you miss up to three appointments during any 30-day period, your physician will be notified. Additionally, you will be required to return to your referring physician for a new prescription before returning to therapy as you will be discharged from therapy.

❑ I have read the above and understand that my attendance and full participation in the program are necessary for my maximum recovery.

Acknowledgement of Review of Notice of Privacy Practices

I have been offered a copy of this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

_____ _____

Patient's Name (Printed) **Date**

_____ _____

Patient's Signature (or Guardian, if a Minor) **Witness (Optional)**