PATIENT REGISTRATION

PATIENT INFORMATION (Please Print)

Last Name:____________ First Name:____________ Middle Initial:______ Nickname:__________

Date of Birth:____________ Social Security Number: NOT NEEDED Age:__________

Address:______________________________ Apartment:__________

City:____________ State:____________ Zip:__________ County:__________

Primary Phone:____________ ☐Home ☐Mobile ☐Work ☐Other:__________

Secondary Phone:____________ ☐Home ☐Mobile ☐Work ☐ Other:__________

Email:____________ Would you like to receive appointment reminders? ☐ Email ☐Text ☐Phone
(Not available in all locations. See front office for availability)

Preferred Language:____________ Do you require an interpreter? ☐Yes ☐No

Relationship Status ☐Single ☐Married ☐Civil union ☐ Life Partner ☐Divorced ☐Widowed

Gender Identity ☐ Male ☐ Female ☐ Other Category:____________ ☐Decline to answer

What sex were you assigned at birth? ☐Male ☐Female ☐Decline to answer

Employer/School:____________ Occupation:____________

Employment Status Employed: ☐ Full-Time / ☐ Part-Time ☐Self Employed ☐Child ☐Active Duty Military

Student: ☐ Full-Time / ☐ Part-Time ☐Unemployed ☐Disabled ☐Retired (date):__________

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:____________ Phone:____________ Relationship:__________

Emergency Contact Name:____________ Phone:____________ Relationship:__________

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient ☐Self (if self, skip to Insurance Information) ☐Parent ☐Spouse ☐ Other

Last Name:____________ First Name:____________ Middle Initial:__________

Date of Birth:____________ Social Security Number: NOT NEEDED

Address:____________ Apt #:______ City:__________ State:______ Zip:__________

Primary Phone:____________ ☐Home ☐Mobile ☐Work ☐Other:__________

PRIMARY INSURANCE INFORMATION (Required)

Insurance Company:____________ Phone__________

Subscriber Name:____________ SSN: NOT NEEDED Date of Birth__________

Policy ID Number:____________ Group Number:__________

Relationship to Patient: ☐Self ☐Mother ☐Father ☐Spouse ☐Other (Please specify):__________

SECONDARY INSURANCE INFORMATION (Required if you have a secondary plan)

Insurance Company:____________ Phone__________

Subscriber Name:____________ SSN: NOT NEEDED Date of Birth__________

Policy ID Number:____________ Group Number:__________

Relationship to Patient: ☐Self ☐Mother ☐Father ☐Spouse ☐Other (Please specify):__________

AUTHORIZATION TO RELEASE INFORMATION

If you would like the details of your (or the patient's, as identified on the first page of this form) treatment, test/lab results, and/or payment information, to be communicated to anyone other than you, the patient/guarantor, please complete the information below identifying such person.
***Please note, all Medical Records requests must be submitted to our Medical Records department for processing and cannot be released by your individual clinic. Please allow up to thirty (30) days for processing.*

Name (printed)	Relationship to Patient	Information to be released
Parent/Guardian Name (printed)	Relationship to Patient	Information to be released

I hereby authorize PT Solutions to release the above listed information to the individual(s) written above.

Patient/Parent/Guardian Signature ____________________ Date ____________________

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE OF INFORMATION, CONSENT FOR TREATMENT, RESPONSIBILITY OF PAYMENT, AND MEDICAL RELEASE

I, the undersigned, hereby authorize for myself (or on behalf of the patient in my capacity as authorized representative of the patient identified on the first page of this form), PT Solutions to provide, perform, and furnish to me (or to the patient) any and all physical therapy treatments, including any tests and/or procedures, that are considered appropriate or advisable by my (or the patient's) physician.

I further authorize PT Solutions to release to my (or to the patient's) insurance company and to my (or to the patient's) physicians, any medical information acquired by PT Solutions in the course of providing my (or the patient's) treatment. I acknowledge and expressly guarantee payment in full of any and all claims and charges in consideration for medical services rendered to me (or to the patient) by PT Solutions. If for any reason my (or the patient's) account should become delinquent, I agree to pay all rebilling charges, costs related to collection efforts, and reasonable legal fees related to such collection efforts by PT Solutions.

PRIVACY NOTICE

I, the undersigned, do hereby acknowledge for myself (or on behalf of the patient in my capacity as authorized representative of the patient identified on the first page of this form), that I have been made aware of PT Solutions' legal duties, policies, and procedures, regarding the protection of my (or the patient's) personal health information and that I have received a copy of PT Solutions' notice of privacy practices describing these policies and protections, and further acknowledge that a copy of PT Solutions' notice of privacy practices is available on the PT Solutions website. I understand and agree that, unless I request otherwise in writing, PT Solutions will communicate with me via phone, fax, and/or email, and will state the company name (PT Solutions) when leaving messages for me (or the patient) via any of these means.
PT Solutions will never communicate or otherwise provide medical advice via answering machine, voicemail, messages with family members, email, or fax.

I acknowledge and understand that I may contact PT Solutions' Compliance Director should I have questions or comments regarding PT Solutions' privacy practices at **678-402-2002 / compliance@ptsolutions.com**.

I hereby certify that the medical history provided is true and accurate to the best of my knowledge. I further acknowledge that I have read and understand the consents, authorizations, and policies as described above.

Electronic Signature Disclaimer: By signing your name electronically, you are agreeing that your electronic signature is the legal equivalent of your manual signature.

Patient/Guardian Signature ____________________ Date ____________________

MEDICATION LISTING

Welcome to PT Solutions Physical Therapy. Whether you are seeing your PCP or your physical therapist, providing a list of your medications with the name, dosage and frequency helps to provide you with the best care possible. Medications can affect your heart rate and blood pressure, and may even cause dizziness, muscle soreness and fatigue, among other side effects. Participation in therapy may cause these same symptoms. Knowing what medications, you are taking helps the therapist design the best program for you.

Patients Name: ______________________________ **Date of Birth:** ____________________

Please list the name, dose, how often, reason, and the last dose of each medication in the table below

Information provided by: ☐ Patient ☐ Family ☐ Written List Attached ☐ Other ____________________

Medication (include strength)		Dose	Frequency	Reason	Last Dose
Example:	Aspirin	325 mg	Daily	Heart	*i.e. date discontinued or added*
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

APPOINTMENT AND CANCELLATION POLICY

Cancellation of an Appointment

Our goal is to provide quality rehab care in a timely manner. In order to be respectful of the rehab needs of all PT Solutions patients, **please be courteous and call our office promptly if you are unable to attend an appointment.** This time will be reallocated to someone who is in need of treatment.

Appointments are in high demand, and your early cancellation will give another patient the opportunity to have access to timely medical care.

PT Solutions reserves the right to charge a cancelation fee of $40 if your appointment is not canceled within 24 hours of your scheduled appointment.

______________________________ ____________________
Patient/Guardian Signature Date

CURRENT INJURY / DISORDER INFORMATION

Referring Provider:____________________ What is your injury or concern?____________________

What is the nature of your current injury?

☐ Recreational ☐ Chronic/Reoccurring ☐ Fall ☐ Insidious ☐ Surgery

☐ Work Related – Injury Date: __________ ☐ Auto Accident - Date: __________ ☐ Other__________________

Have you had surgery for this injury/disorder? ☐ Yes ☐ No Date and type of Surgery:__________________

Are you currently receiving, or have you received Home Health Care within the past 60 days? ☐ Yes ☐ No

If yes, where? ______________ Have you been discharged? ☐ Yes ☐ No Discharge Date?______________

Have you received Physical, Occupational, or Speech Therapy within this calendar year? ☐ Yes ☐ No

If yes, what type of therapy?__________ Where was the treatment?____________ ☐ Inpatient ☐ Outpatient

PATIENT MEDICAL HISTORY

What is your goal for therapy?____

How often do you exercise more than 20 minutes per day? ☐ 1-2x a week ☐ 3-4x a week ☐ 5-6x a week ☐ Every day

Do you smoke? ☐ Yes, _____ packs per day ☐ No Are you pregnant? ☐ Yes ☐ No

List any recent Diagnostic testing you have had for this injury (X-ray, MRI, CT Scan, EMG, Injections, etc.): ____________

____

Do you have any allergies to latex, cold, or heat? ☐ Yes ☐ No If yes, please specify:__________________

Have you fallen in the last year? ☐ Yes ☐ No If yes, how many times?__________________

PAST MEDICAL HISTORY

Have you recently noted any of the following? (check all that apply)

☐ Fatigue	☐ Nausea/Vomiting	☐ Unexpected Weight Gain/Loss	☐ Numbness/Tingling
☐ Constipation	☐ Fever/Sweats/Chills	☐ Pain that keeps you awake	☐ Changes in Appetite
☐ Visual Changes	☐ Difficulty Swallowing	☐ Rapid Heart Rate/Palpitations	☐ Changes in Bowel or Bladder
☐ Incontinence	☐ Dizziness/Lightheaded	☐ Recent onset of Headaches	☐ Unexplained Cough
☐ Fainting	☐ Muscle Weakness	☐ Shortness of Breath	☐ Urinary Tract Infection

☐ Prior Surgeries, please describe:____

Have you ever been diagnosed with the following? (check all that apply)

☐ Anemia	☐ Bone/Joint Infections	☐ High/Low Blood Pressure	☐ Back Pain (Degenerative, Stenosis, Herniation)
☐ Asthma/Allergies	☐ Seizures or Epilepsy	☐ Lung Disease/COPD/ARDS	☐ GI Disease (Liver, Ulcer, Hernia, Reflex, Gallbladder)
☐ Pneumonia	☐ Diabetes Type 1 or 2	☐ Bladder/Urinary/Kidney Disease	☐ Vascular/Circulation Problems/Blood Clots
☐ Cancer (any)	☐ Chronic Headaches	☐ Osteoarthritis/Rheumatoid Arthritis	☐ Depression/Anxiety/ Panic Disorders
☐ Stroke/CVA/TIA	☐ TB/HIV/Hepatitis A/B/C	☐ Congestive Heart Failure/Heart Attack	☐ Neurological Disease (MS, Parkinson's)
☐ Thyroid Condition	☐ Chest Pain or Angina	☐ Visual or Hearing Impairments	☐ Other(s)

Patient Name:____________________ Date of Birth:____________________ FIN:______________

OREGON DIRECT ACCESS DISCLOSURE

Thank you for choosing Stride Strong! Under Oregon law, patients are allowed total, unrestricted access to a physical therapist without requiring a referral from your physician.

A physical therapy diagnosis is not reliant on radiological imaging and identifies why you are seeking physical therapy treatment and is not the same as a medical diagnosis. In order to determine a medical diagnosis, you will need to schedule an appointment with an appropriate licensed healthcare professional.

Your physical therapist must refer you to an appropriate healthcare professional if your present symptoms:

- Require treatment or a diagnosis from a physician;
- For which physical therapy is contraindicated; or
- For which care is beyond the scope of practice or education of a physical therapist.

Although most insurance carriers allow Direct Access, there are a few that may still require a physician's referral before they will pay for services.

The following plans cannot be billed for direct access physical therapy treatment provided by Stride Strong Physical Therapy:

Tricare, Medicare, Medicaid, Worker's Compensation, Motor Vehicle Accidents, or any plan requiring prior authorization by your insurance.

Any balances not covered by your insurance will be your responsibility to pay.

I hereby acknowledge that I have read the above disclosure and I understand that a physical therapy diagnosis is not the same as a medical diagnosis.

Patient Signature ______________________ Date ______________________

Parent/Guardian Signature ______________________ Relationship to Patient ______________________