PATIENT REGISTRATION

PATIENT INFORMATION (Please Print)

Last Name:_____ First Name:_____ Middle Initial: _____ Nickname:_____

Date of Birth:_____ 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:_____

Address:_____ Apt #:_____ City:_____ State:_____ Zip:_____

Primary Phone:_____ ☐ Home ☐ Mobile ☐ Work ☐ Other:_____

PRIMARY INSURANCE INFORMATION (Required)

Insurance Company:_____ Phone_____

Subscriber Name:_____ Date of Birth_____

Policy ID Number:_____ Group Number:_____

Relationship to Patient: ☐ Self ☐ Mother ☐ Father ☐ Spouse ☐ Other (Please _____

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

Insurance Company:_____ Phone_____

Subscriber Name:_____ Date of Birth_____

Policy ID Number:_____ Group Number:_____

Relationship to Patient: ☐ Self ☐ Mother ☐ Father ☐ Spouse ☐ Other (Please _____

specify):

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)

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 cancellation fee of $40.00 if your appointment is not canceled within 12 hours of your scheduled appointment. Patient Signature _____

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 _____

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MEDICARE SECONDARY PAYOR (MSP) QUESTIONNAIRE

To be completed by all patients carrying Medicare and Managed Medicare plans

Patient Name _____ Date of Birth _____

Please read and respond to each of the following:

1. **Patient Employment Status:**
   ◯ Not Employed (Disabled, etc.)
   ◯ Employed (Full-Time, part-time, self-employed)

   Employer Name: _____ Number of employees at the company: _____

   ◯ Retired – if retired, Retirement Date: _____

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2. **Spouse Employment Status:**
   ◯ Not Employed (Disabled, etc.)
   ◯ Employed (Full-Time, part-time, self-employed)

   Employer Name: _____ Number of employees at the company: _____

   ◯ Retired – if retired, Retirement Date: _____

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3. **Other Insurance:**
   Does the patient have Group Health Insurance (GHP) through either themselves or a family member's current employment? ◯ Yes ◯ No If yes, Insurance Company Name _____

   Note: Medicare pays Primary if patient is 65 or older, is covered by a GHP through current employment or spouse's current employment AND the employer has less than 20 employees. Medicare pays secondary if employer has 20 or more employees. Obtain copy of GHP Insurance Card

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4. **Black Lung:**
   Is the patient receiving Federal Black Lung benefits? ◯ Yes ◯ No If yes, date started: _____

   Note: Black Lung is responsible for claims related to Black Lung.

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5. **Government Program:**
   Are the services to be paid by a government research program? ◯ Yes ◯ No

   Note: Medicare will not cover services related to a research program

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6. **Veterans Administration:**
   Has treatment for this accident or illness been authorized by the Veterans Administration? ◯ Yes ◯ No
   Note: DVA is responsible for services for patients with approval letters or when the service is war-related.

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7. Accident Information:

Is your illness/injury due to any of the following: ◯ Yes ◯ No

◯ Work Related Date of Injury: _____

◯ Automobile Accident Date of Accident: _____

◯ Accident on Property (other than your own) Date of Accident: _____

Please give details of the accident: _____

_____

_____

Do you intend to file a liability claim or lawsuit in connection with this injury or illness? ◯ Yes ◯ No

If yes, please provide the name, address and contact information of the liability insurance:

Insurance Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Contact/Adjuster: _____ Claim #_____

Note: Medicare regulations require us to file with the above liability insurance first, even if they will not pay directly or immediately. We must comply with this regulation before filling Medicare.

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8. Entitlement:

Is Medicare entitlement based on (*Select all that apply)*

◯ Age ◯ Disability ◯ ESRD

If ESRD, answer questions below.

End Stage Renal Disease (ESRD):

1. Has the patient received a kidney transplant? ◯ Yes ◯ No If yes, date of transplant: _____
2. Has the patient received dialysis treatments? ◯ Yes ◯ No Date dialysis began: _____
3. Has the patient participated in self-dialysis training? ◯ Yes ◯ No If yes, date started: _____
4. Is the patient within the 30-33 month coordination period? ◯ Yes ◯ No
5. Is Medicare entitlement based on ESRD and Age **or** ESRD & Disability ◯ Yes ◯ No
6. Was the patient's initial entitlement to Medicare based on ESRD? ◯ Yes ◯ No

Patient Signature _____ Date _____