Innovative Physical Therapy, LLC

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Innovative Physical Therapy LLC
Registration Forms

First Name _____ Date of injury/onset _____ Today's Date _____

Last Name _____ Date of Birth _____ Age _____

Social Security: _____-_____-_____ Sex: M F Marital Status: S M D W

Address _____

City _____ State _____ Zip _____

Employer: _____ E-Mail: _____

Home Phone: ( ) _____-_____ Work Phone: ( ) _____-_____

Injury Area: _____ Accident Related? Y N If yes, Auto Work

Referring Physician: _____ Phone ( ) _____-_____

Primary Insurance _____ Policyholder _____

Policyholder's Date of Birth: _____ Policyholder's SS# _____

Group # _____ Member ID # _____

Emergency Contact _____ Phone: ( ) _____-_____

How did you hear about us: _____

Are you receiving or have you recently received home health services? Yes No
Are you receiving or have you received other therapy services? Yes No

Please initial after reading statements:

1. Consent to Treatment: I consent to rehabilitation and related services at Innovative Physical Therapy LLC. In so doing, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature. _____

2. Treatment of Minor: I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. _____

3. Liability: I know and agree that Innovative Physical Therapy LLC is not responsible for loss or damage to personal valuables. _____

4. Authorization of Payment: I hereby assign all benefits directly to Innovative Physical Therapy LLC and authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I received, I will be financially responsible for payment. _____

Patient Signature: _____Date: _____

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question leave it blank and your therapist will assist you. Thank you!

NAME:_____ LEISURE ACTIVITIES:_____
OCCUPATION_____

ALLERGIES: List any medication(s) you are allergic to:_____

Are you latex sensitive? Yes No List any other allergies we should know about _____

Have you declared the Advanced Clinical Directive of Do Not Resuscitate? Yes No

Please check any of the following whose care you're under

____ Medical doctor (MD)	____ Psychiatrist/Psychologist	Other_____
____ Osteopath	____ Physical Therapist	
____ Dentist	____ Chiropractor	

If you have seen any of the above during the past three months, please describe for what reasons (illness, medical condition, physical, etc): _____
_____

Have you EVER been diagnosed as having any of the following conditions?

Yes No Cancer. If YES, describe what kind:_____
Yes No Heart Problems
Yes No High blood pressure
Yes No Circulation problems
Yes No Asthma
Yes No Emphysema/Bronchitis
Yes No Chemical dependency (i.e., alcoholism)
Yes No thyroid problems
Yes No Diabetes
Yes No Multiple sclerosis
Yes No Rheumatoid arthritis
Yes No Other arthritic conditions
Yes No Depression
Yes No Hepatitis
Yes No Tuberculosis
Yes No Stroke
Yes No Kidney disease
Yes No Anemia
Yes No Epilepsy
Yes No Other

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
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO
FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO
Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

DATE	REASON FOR SURGERY/HOSPITALIZATON		
1. _____	_____	2. _____	_____
3. _____	_____	4. _____	_____
5. _____	_____	6. _____	_____

Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of Injury:

DATE	INJURY	DATE	INJURY
_____	_____	_____	_____
_____	_____	_____	_____

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

YES NO Diabetes
YES NO Tuberculosis
YES NO Heart disease
YES NO High blood pressure
YES NO Stroke
YES NO Kidney disease
YES NO Alcoholism (chemical dependency)
YES NO Cancer
YES NO Arthritis
YES NO Anemia
YES NO Headaches
YES NO Epilepsy
YES NO Mental illness

Which of the following OVER-THE-COUNTER medications have you taken in the last week?

YES NO Aspirin
YES NO Tylenol
YES NO Advil/Motrin/Ibuprofen
YES NO Laxatives
YES NO Decongestants
YES NO Antihistamines
YES NO Antacid
YES NO Vitamins/mineral supplements
YES NO Other _____

Please list any PRESCRIPTION medication you are currently taking (INCLUDING pills, injections, and/or skin patches):

1._____ 2. _____ 3._____

4. _____ 5. _____ 6. _____

How much caffeinated coffee or caffeine containing beverages do you drink per day? _____

How many packs of cigarettes do you smoke a day? _____

How many days per week do you drink alcohol? _____

If one drink equals one beer or glass of wine, how much do you drink at an average sitting? _____

Have you recently noted:

YES NO weight loss/gain
YES NO nausea/vomiting
YES NO dizziness/lightheadedness
YES NO fatigue
YES NO weakness
YES NO fever/chills/sweats
YES NO numbness or tingling

_____ _____ _____ _____
Therapist signature Date Patient signature Date

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that as part of my healthcare, Innovative Physical Therapy originates and maintains health records describing my health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future care and treatment. I also understand that this information serves as:
A basis for planning my care and treatment

- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a **Notice of Privacy Practices** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand the Practice reserves the right to change their notice and practices, and prior to implementation, will mail a copy of any revised notice to the address that I have provided if there is a need to use or disclose any protected health information. I also understand that I have the right to restrict as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.
With this consent, Innovative Physical Therapy may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out routine office procedures, such as appointment reminders, insurance items and any calls pertaining to my clinical care, among others.
With this consent, Innovative Physical Therapy may mail to my home or other alternative location any items that assist the practice in carrying out routine office procedures, such as appointment reminder cards and patient statements.
By signing this form, I am consenting to allow Innovative Physical Therapy to use and disclose my protected health information to carry out routine office procedures.

Signature of Patient/Parent/Legal Guardian Date Relationship to Patient

_____

Print Patient's Name Print Name of Legal Guardian

_____

CREDIT & ASSIGNMENT OF BENEFITS POLICY

Our credit policy is designed to provide a clear understanding that the patient/guarantor is ultimately responsible for payment of all medical services. Because of our primary responsibility to provide the patient with the best possible medical treatment, while making every effort to effectively control rising medical costs, we expect payment at time of service for all non-insured patients, plan deductibles, and co-pays. Payment can be charged to your credit card. We participate with most major insurance providers and, as a courtesy, will submit all valid insurance claims to the appropriate insurance company in a timely fashion. We at Innovative Physical Therapy are very sensitive to situations in which special payment arrangements may be necessary. These cases are handled on an individual basis and must be approved before treatment is rendered. All unpaid patient responsible balances not paid in 30 days (except for qualified pending insurance claims) will be assessed a finance charge of 1.5% (18% annual rate) per month of the unpaid balance and 33.3% attorney's fee if referred to an attorney for collections. The guarantor and/or patient shall be responsible for all costs incurred to collect any unpaid balances. There is also a $50.00 charge to the guarantor/patient for each returned check.

APPOINTMENT POLICY

If you are unable to keep a scheduled appointment, we ask that you give us at least 24 hours' notice. Late cancellations and "No Shows" are charged a $50.00 fee. A "No Show" for an evaluation appointment will be charged a $75.00 fee. Your insurance will not reimburse these charges. We recognize that unforeseen situations occur, therefore we will allow for one courtesy cancellation or no show.

RECORDS RELEASE

I/We hereby authorize Innovative Physical Therapy, LLC its agent(s), any insurance company or doctor, my attorney or legal representative, to furnish any information to, or request from such designates any and all requested information concerning my illness or injury. Medical and/or financial records will be maintained for six years from the last date of service.

KNOW YOUR INSURANCE COVERAGE AND BENEFITS

Your health insurance is a contract between you and your health insurance plan(s). It is your responsibility to know the amount of your co-payment and for understanding your health insurance benefit coverage, referral and authorization requirements. Please be aware that individual contracts have huge variances on what is or is not covered, and the percentage or dollar amount at which procedures are covered. Innovative Physical Therapy is not and will not be held responsible for knowing or tracking your benefits, or limitations of your benefit plan. This is your responsibility so please contact your insurance company to better understand your Physical Therapy benefits.

I/We understand that it is my responsibility to pay any balance accrued (due to insurance co-payments, co-insurance, deductibles, termination of coverage, non-covered services by my insurance carrier, maxed benefits, etc.). I agree to pay all charges within 30 days or be subject to the penalties as stated above.

_____ _____

Signature of patient/Parent/Legal Guardian Date

MEDICAL INFORMATION RELEASE FORM

Name: _____ Date of Birth: ____/___/___

RELEASE OF INFORMATION

( ) I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

( ) Spouse _____

( ) Child (ren) _____

( ) Other _____

( ) Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

MESSAGES

Please call ( ) my home ( ) my work ( ) my cell number: _____

If unable to reach me:

( ) you may leave a detailed message

( ) please leave a message asking me to return your call

( ) _____

The best time to reach me is (day) _____ between (time) _____

Signed: _____ Date: ___/___/____

Witness: _____ Date: __/___/___