

Patient Registration Form



PATIENT INFORMATION:

Last Name _____ First Name _____
Address _____ Social Security # _____
City/State/Zip _____ Male Female Date of Birth _____
Home Phone _____ Work Phone _____
Cell Phone _____ Fax _____
Email Address* _____ Employer's Name _____
Occupation _____

*For Schedule info only. Check here if you **do not** wish to receive our quarterly email newsletter.

EMERGENCY CONTACT:

Name _____ Relationship _____
Telephone _____ Alternate # _____

HOW DID YOU FIND OUT ABOUT US?

Friend of Family Member Name of Friend _____
 Website Phone Book/Yellow Pages Video Physician Former Patient Drove by
 Ad Insurance Company Internet Search Engine _____ Other _____

PHYSICIAN WHO WROTE YOUR PRESCRIPTION:

Name _____ Telephone # _____

ALL OTHER PHYSICIANS:

Name _____ Specialty _____
Name _____ Specialty _____
Name _____ Specialty _____
Name _____ Specialty _____

INSURANCE:

Medicare Private Work Comp Cash

Have you had Physical, Occupational, Speech or Chiropractic Therapy in the past year?

Yes No Where? _____ How many visits? _____

Patient Health Questionnaire



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!

Patient Name: _____ **Sex:** M / F (Please circle one) **Weight:** _____ **Height:** _____

I. Please check any of the following whose care you are under:

- Medical Doctor (MD) Psychiatrist/Psychologist Other _____
 Osteopath Physical Therapist
 Dentist Chiropractor

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

II. Have you ever been diagnosed as having any of the following conditions?

- Y N 1. Do you wear external protection garments for bladder leakage or incontinence? Day Night
Y N 2. Do you have stress or urge incontinence?
Y N 3. Do you take stool softeners or laxatives?
Y N 4. Cancer. If YES, describe what kind and date of diagnosis: _____
Y N 5. Heart Attack
Y N 6. Heart Arrhythmia
Y N 7. Heart Valve Problems
Y N 8. Do you have a pacemaker?
Y N 9. Deep Venous Thrombosis (Blood Clots)
Y N 10. High Blood Pressure
Y N 11. Circulation Problems
Y N 12. Asthma
Y N 13. Emphysema/Bronchitis
Y N 14. Chemical Dependency (i.e., alcoholism)
Y N 14. Thyroid Problems
Y N 16. Diabetes
Y N 17. Multiple Sclerosis
Y N 18. Rheumatoid Arthritis
Y N 19. Other Arthritic Conditions
Y N 20. Depression
Y N 21. Hepatitis
Y N 22. Stroke
Y N 23. Kidney Disease
Y N 24. Anemia
Y N 25. Epilepsy / Seizures
Y N 26. Osteoporosis
Y N 27. Dementia
Y N 28. Other _____

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III. Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for surgery or hospitalization:

DATE	REASON FOR SURGERY/HOSPITALIZATION
1. _____	_____
2. _____	_____
3. _____	_____

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IV. Please describe any significant injuries for which you have been treated (fractures, dislocations, sprains, etc) and the approximate date of injury:

	DATE	INJURY
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

V. Please list all prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary supplements you are currently taking:

	MEDICATION NAME	DOSAGE	FREQUENCY	ROUTE OF ADMINISTRATION
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
7.	_____	_____	_____	_____
8.	_____	_____	_____	_____

VI. General Health Questions:

1. During the past month have you been feeling down, depressed or hopeless? YES NO
2. Do you ever feel unsafe at home or has anyone hit or tried to injure you in any way? YES NO
3. How many cigarettes do you smoke per day? _____ Do you chew tobacco? YES NO
4. How much caffeinated coffee or caffeine containing beverages do you drink per day? _____
5. How many days per week do you drink alcohol? _____ Average # of drinks per sitting? _____
6. Women: Are you currently pregnant or think that you might be pregnant? YES NO

VII. Have you recently noted any of the following?

- Y N 1. Weight Loss / Gain
- Y N 2. Nausea / Vomiting
- Y N 3. Fatigue
- Y N 4. Weakness
- Y N 5. Fever / Chills / Sweats
- Y N 6. Numbness / Tingling

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VIII. Other Comments:

Therapist Signature

Date

Informed Consent to Physical Therapy and Care



I hereby request and consent to the performance of physical therapy treatments and other procedures within the scope of the practice of physical therapy on myself by the physical therapists, physical therapist assistants, aides, or anyone working as an employee for Complete PT Pool & Land Physical Therapy, Inc. who now or in the future treat me.

I understand that methods of treatment may include, but are not limited to, ultrasound, phonophoresis, electrical stimulation, iontophoresis, joint mobilization, soft tissue mobilization, manual stretching, and active exercise on land and/or in the pool. I understand that I must disclose all my medical conditions in order for the safest method of treatment to be enacted.

I have been informed that physical therapy is generally a safe method of treatment, but I may have some side effects, including skin rash, bruising, muscle soreness, pain, fatigue, numbness or tingling. Unusual risks of physical therapy include fracture, nerve damage, joint dislocation, fainting, myocardial infarction, paralysis and death. There is a risk of infection, although the clinic maintains a safe and clean environment. Burns and/or scarring are a potential risk of iontophoresis, ultrasound, phonophoresis, heat, ice, and taping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I understand that some modalities and exercises may not be appropriate with other medical conditions including coronary artery disease, hypertension, cancer or pregnancy and I will notify a clinical staff member if I have a history of, currently have, or am newly diagnosed with any conditions while under CompletePT Pool & Land Physical Therapy's care.

I have been instructed to wear closed pool shoes to and from the pool as well as in the locker room for my

safety. I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks best at the time, based upon the facts then known in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential. CompletePT Pool & Land Physical Therapy may disclose protected health information about me to carry out treatment, payment and healthcare operations. I give permission to CompletePT to release my records to my referring physician and my primary care physician. I will refer to HIPPA guidelines for a more complete description of such uses and disclosures. I understand the clinic may call my home or other designated location and leave a message via voicemail or in person in reference to any items that assist in carrying out my care, such as appointment reminders, insurance, prescription information, etc. The clinic may also contact me via mail to my home or other designated location, with information regarding my care. I have the right to request information be restricted, however I understand that my request may be denied if it interferes with my care.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment and release of information. I have been told about the risks and benefits of physical therapy and other procedures and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient or Representative Signature: _____ **Date:** _____

I verify that I have informed the patient of the above information and he/she appears to have a clear understanding of the risks and benefits of physical therapy as well as the privacy policies held by CompletePT Pool & Land Physical Therapy, Inc.

Therapist Signature: _____ Date: _____

Patient Agreement



ASSIGNING BENEFITS

As a physical therapy patient at CompletePT, I hereby authorize payment directly to CompletePT for all physical therapy services rendered and submitted to my insurance on my behalf. I understand that CompletePT will submit claims to my insurance company on my behalf, but that CompletePT assumes no responsibility for obtaining reimbursement on my behalf.

CHANGE IN INSURANCE COVERAGE

I will inform the office immediately if there is any change in my insurance. I realize that problems can arise resulting in full liability on my part for payment of physical therapy services if I do not keep the office informed of my current insurance information. I understand that I cannot hold CompletePT responsible for any financial losses suffered as a result of claims that are submitted on my behalf with inaccurate or outdated insurance information.

PAYMENTS, RETURNED CHECK FEES, PAST- DUE FEES

I understand that all payment must be by check or credit card (Visa, Mastercard or Amex). If a check is returned I agree to pay a fee of \$25; such fee, and all future payments, must be by cashier's check, or credit card. I understand that unpaid balances of over 30 days from my first statement will accrue interest at 1.5%/ month.

LATE CANCELLED OR MISSED APPOINTMENT FEES

I will call by noon the day before to change or cancel an appointment. I will pay \$25 at my next visit for a late cancellation/misled appointment if I do not call by noon the day before. Insurance does not cover this fee, and it will not be billed to me. If a medical or non-medical emergency occurs, it will be up to the office to decide to waive payment or not.

BALANCES DUE AFTER INSURANCE

I understand that verification of my insurance benefits is not a guarantee of payment. Insurance may cover some of the fees billed, and I agree to pay any balance due. I agree to pay my deductible and copays at the time of service, to educate myself about my benefits with my insurance company, and be aware of my costs. Insurance does not cover electrodes.

- If my therapist determines that electrotherapy is appropriate for my healing, a set of electrodes will be dispensed for my exclusive use, and I agree to pay the \$11 (plus tax) that will be billed to me for each set, which may be used 20 times.
- If my therapist determines that iontophoresis is appropriate for my healing, a set of electrodes will be dispensed at each treatment, for which I agree to pay the \$11 fee at the end of each iontophoresis session.

2019 MEDICARE CAP

I understand that Medicare does not pay for services in excess of \$2040 unless I qualify for an exception to the cap, and exceptions to the cap are applied. I will consult with my therapist regarding exceptions. I will have a re-eval after 16 appointments, or after 4 weeks, whichever comes first. Medicare does not pay for physical therapy if I am receiving home health services of any kind through a home health agency, so I will let CompletePT know immediately if I begin receiving home health care during my treatment here.

PRESCRIPTIONS

I understand it is my responsibility to obtain prescriptions from a medical doctor to initiate and continue treatment. I will educate myself about specific prescription policies of Medicare or my insurance plan.

HOME HEALTH CARE DURING PHYSICAL THERAPY

I understand that Medicare does not cover both Home Health Care and Physical Therapy if I receive them at the same time. I agree to notify CompletePT if I am receiving Home Health Care and I understand that I am responsible for payment in full for my services at CompletePT.

HEALTH INFORMATION PRIVACY NOTICE

I have received a copy of the notice informing me of my privacy rights and understand that my health information will be used for treatment, billing, and office operation only.

NO ABUSIVE LANGUAGE OR PROFANITY

I understand that CompletePT has zero tolerance for patients using abusive language or profanity in the clinic. If I am overheard using such, I understand I will be discharged immediately.

SIGNING IN AND HONORING SCHEDULES

I will arrive on time and sign in at reception. If I arrive more than 10 minutes late, my appointment may have to be re-scheduled. If my appointment is in the pool, I will allow enough time to change and be at the pool by the time of my appointment, and I will wear pool shoes or sneakers from the locker room to the pool. If I arrive early, I will wait for the therapist to call me into the pool. After signing in for a land appointment, I will wait downstairs.

ARBITRATION FORM

I understand that I must read and sign the Physical Therapy Arbitration Agreement form before I will be evaluated and treated.

I have read the above, understand it, and will be a responsible patient and will adhere to this agreement.

Patient Signature _____

Date _____

Signature of Insured if different from patient _____

Date _____

Consent Form



A. _____ Effective immediately, I give my ongoing consent to CompletePT to email or fax schedules, home exercise programs, forms and medical information related to my physical therapy at the email and/or fax listed as follows:
INITIAL

Email: _____

Fax #: _____

(Please initial B or C.)

B. _____ Effective immediately, I give my ongoing consents to CompletePT and the persons named below to discuss and exchange any and all of my Protected Health Information including but not limited to my schedule, medical information, and payment and insurance information, and for these individuals to accompany me to my evaluations, re-evaluations, and treatments appointments.
INITIAL

Please initial and print the names of those that apply:

Spouse:

_____	_____
NAME	INITIAL

Son:

_____	_____
NAME	INITIAL

Daughter:

_____	_____
NAME	INITIAL

Caregiver:

_____	_____
NAME	INITIAL

Other person:

_____	_____
NAME	INITIAL

C. _____ B above does not apply as I attend my appointments alone and conduct all my own communication directly with CompletePT
INITIAL

PATIENT SIGNATURE

DATE

PATIENT NAME