PATIENT REGISTRATION FORM

PERSONAL INFORMATION

Name (last, first, MI):		
Address:		
City:	State:	Zip
Home Phone:	Cell Phone:	Work Phone:
Sex : •M • F	Marital status: • Married • Single	Email:
Referring MD:	Referring MD phone:	
Primary care MD:	Primary care MD phone:	

INSURED/RESPONSIBLE PARTY INFORMATION: Same as above: •Yes •No (if yes, leave this section blank)

Insurance Policy #:		DOB:
Name (last, first, MI):		
Address:		
City:	State:	Zip
Home Phone:	Cell Phone:	Work Phone:
Sex : •M • F	Marital status: • Married • Single	Email:
Relationship to patient:		

PATIENT EMPLOYER INFORMATION

Employment status: • Full time •Part time • Retired •Student •Unknown		
Employer name:	Job title:	
Employer address:		
City:	State:	Zip:

EMERGENCY CONTACT

Emergency contact name (last, first, MI):		
Relationship: : • Spouse •Parent • Friend •Other		
Home phone:	Cell phone:	Work phone:

I certify that all the information provided above is correct to the best of my knowledge.

Patient/Guardian signature: _____ Date: _____

PATIENT AUTHORIZATON FORM

Patient Name: _____ Date: _____ DOB: _____

Informed Consent and Release of Information

I understand that as a patient of Thrive Integrative Physical Therapy and Sports Rehab (Thrive PT):

I have the right to receive complete and current information concerning my diagnosis, treatment, and any known prognosis. This information will be communicated to me by my therapist in terms I can understand.

- I have the right to accept medical care or to refuse treatment to the extent permitted by law and to be informed of the medical consequences if I refuse treatment. I understand that if I refuse recommended treatment, Thrive PT has the right to discharge me from therapy.
- Patient rights will be posted in a prominent location for my review and I can discuss any questions with my therapist.
- I understand that rehabilitative care may involve bodily contact, touching and /or direct contact as a part or an evaluative, assessment, and/or treatment process.
- I give Thrive PT permission to release information verbal and/or written contained within my medical record to my insurance company, case manager, attorney, employer, and healthcare practitioner as they relate to my treatment or payment of treatment.
- I give Thrive PT permission to obtain medical records and health information from my physician or other medical professional as it related to my treatment.

ASSIGNMENT OF BENEFITS

I authorize payment directly to Thrive PT for services and to bill and release payment directly to Thrive PT for any physical therapy services provided. I hereby assign all benefits directly to Thrive PT and authorize release of any medical records necessary to process medial claims forms. *I understand that in the event my insurance company or financially responsible party does not pay for the services, I will be financially responsible for payment.*

ATTORNEY'S FEES

You agree to pay, in addition to the balance due, an amount equal to thirty-three and one-third percent (33-1/3%) {or the maximum permitted by law, whichever is less} of the balance due as attorney's fees if this account is referred to an attorney for collections and any court costs associated with such case.

NOTICE OF PRIVACY PRACTICES (HIPAA ACKNOWLEDGEMENT/CONSENT)

I consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and healthcare operations. A copy of the Notice of Privacy Practices for Thrive PT is available upon request.

PATIENT INFORMATION SHEET

I acknowledge that the information provided on the patient intake form is correct to the best of my knowledge.

Patient/Guardian signature: _____ Date: _____

MEDICAL HISTORY QUESTIONNAIRE

Patient Name		**Date of Birth**		**Age**	
Referring Physician		**Diagnosis**			
Reason for Therapy		**Date of Onset**			
Height:	**Weight:**	**Are you or could you be pregnant: Yes No**			

Are you *currently* receiving any other care for the above condition? Yes No
If yes, please explain:

Previous treatment:

Have you received physical therapy within the past year? Yes No
If yes, please explain:

Are you presently working? Yes No Was this a work injury? Yes No

Was your injury the result of an automobile accident? Yes No
Is there an attorney involved in your injury? Yes No

Do you now have or have you ever had any of the following conditions? Please circle:

Arthritis	Diabetes	Numbness/Tingling
Osteoporosis	Anemia	Thyroid problems
High Blood Pressure	Swelling in the extremities	Headaches
Heart Disease	History of DVT	Head injuries/concussions
Heart Attack	Seizures	Hernia
Pacemaker	Fatigue/weakness	Kidney/bladder problems
Stroke	Cancer	Fractures
Asthma	Recent weight loss/gain	Previous surgeries
Shortness of Breath	HIV/AIDS	Metal or surgical implants
Dizziness/Light headedness	Hepatitis	Depression
Falls	Tuberculosis	Anxiety
Nausea/Vomiting	Recurring infections	Smoking
		Other: _____

If you answered "yes" to any of the above conditions, please explain:

Do you have any allergies? Yes No Please list:

Are you presently taking any medications? Yes No Please list:

How would you rate your current health? Excellent Good Fair Poor

The information above is correct to the best of my knowledge.

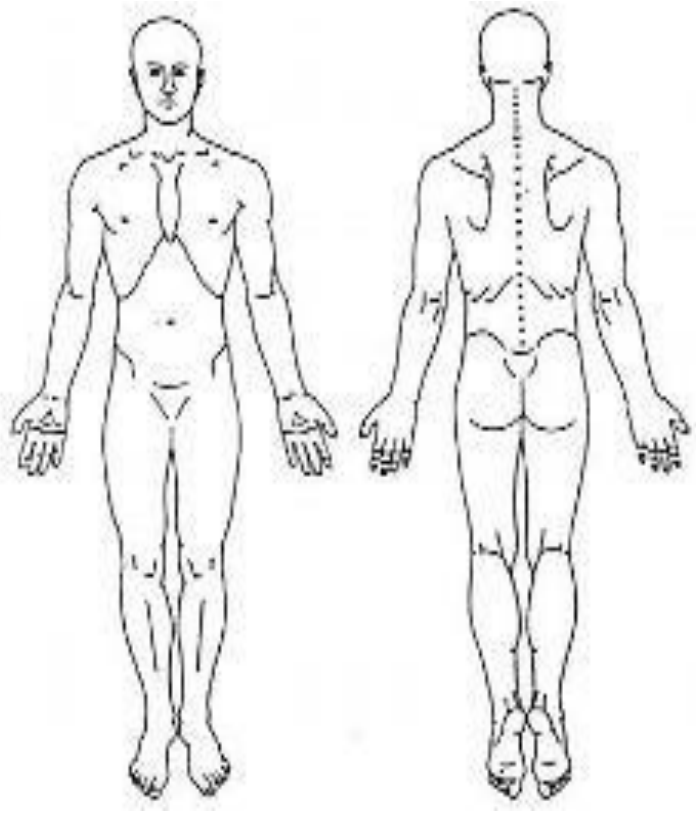
X_____ _____
Patient/Parent/Guardian signature Date

PAIN DIAGRAM AND PAIN RATING

Patient Name		**Date**	

Please use the diagram to indicate the symptoms you have experienced with your condition. Use the key below to indicate the type of symptoms:

Dull/Ache	sssssss		
Pins/Needles	0000000	Sharp/Stabbing	///////
Burning	xxxxxxxx	Pulsing/Throbbing	zzzzzzzz



Is your pain constant or intermittent? Please circle one.

Please rate your current level of pain on the following scale: (circle)

0 1 2 3 4 5 6 7 8 9 10

(no pain) (worst pain)

CANCELLATION/NO SHOW POLICY

Thank you for choosing us for your physical therapy needs. On your first visit, one of our physical therapists will perform an evaluation with you and discuss your plan for recovery. This will include determining the frequency of care that will best allow you to meet your goals for recovery. It is important to maintain consistency in your care in order to best meet your goals.

If you are unable to attend one of your appointments, please kindly provide us with ***24 hours' notice*** so that we may be able to fill the available scheduling void. You may be asked to reschedule the missed visit within the week if possible. Please call if you are going to be late to see if the schedule can be accommodated.

If you do not call to cancel and fail to show, there is a ***$50.00 charge billed to the patient*** for each instance in which this occurs. If there are consecutive/consistent appointment no shows, it is the therapist's discretion to discontinue treatment.

Thank you for your cooperation with this this policy. The goal is for your care and the care of our other clients to be as seamless and unobstructed as possible. We look for to treating you.

I understand the above policy and will ask for clarification when needed.

Patient signature: _____ Date: _____