PATIENT REGISTRATION

PATIENT INFORMATION – Please Print		
Patient Name (Last, First, MI):		**DOB:** **AGE:**
Address:		**SSN:**
City, State, Zip:		**Gender:** ☐ Male ☐ Female
Home Phone:	**Cell Phone:**	
E-mail Address:		**Marital Status:** ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Authorized Communication Method (check all that apply): ☐ Mail ☐ Home Phone ☐ Cell Phone ☐ E-mail		
Employer Name:		**Work Phone:**
Employer Address:		**May we contact you at work?** ☐ Yes ☐ No
Employer City, State, Zip:		
Spouse Name:		**Spouse SSN:**

EMERGENCY & GUARDIAN CONTACT INFORMATION	
Guardian Name:	**DOB:**
Guardian SSN:	**Relationship to Patient:**
Emergency Contact Name:	
Phone:	**Relationship to Patient:**

INSURANCE INFORMATION		
If you are not the Policy Holder, please fill out completely:	**Primary**	**Secondary**
Insurance Company Name		
I.D. / Policy Number		
Group Number		
Policyholder Name		
Policyholder Address (if different than patient)		
Policyholder Date of Birth		
Policyholder Social Security #		

Reason for Visit: ☐ New Illness / Pain / Injury ☐ Recurrent Illness / Injury ☐ Sports Injury ☐ On-the-Job Injury ☐ Motor Vehicle Accident ☐ Other:_____

Date of Accident/Injury:	**Referring Physician:**
Claim Number:	**Primary Physician:**
Adjustor's Name:	**Approximate Date of Onset:** _____ /_____ /_____ Month Day Year
Adjustor's Phone:	**Area(s) of body affected:**

_____ _____ _____

Patient Signature | Parent/Guardian Signature (Required if patient is under 18) | Date

AUTHORIZATION & GUARANTEE

NAME_____ DOB: _____

CONSENT FOR TREATMENT: "I understand I have the right to choose my physical therapy provider and have chosen this facility and hereby consent to all treatment which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while a patient at Physical Therapy Associates, Inc. I further acknowledge that a copy of this agreement shall be valid as the original."

GUARANTEE OF PAYMENT (not applicable for Worker's Compensation patients): "In consideration of services rendered to me by Physical Therapy Associates, Inc., I hereby guarantee payment for any and all services not covered or allowed by insurance. I also understand that all bills are due and payable upon receipt. I understand that the patient responsibility portion of my bill will be due and payable at the time of service. I understand that should my account with Physical Therapy Associates, Inc. become delinquent and turned over to a collection agency, that I, the undersigned, will be responsible to pay all collection agency fees, court costs or any other fees/costs associated with resolving my account."

INSURANCE BENEFITS (if applicable): As a courtesy, we will make every effort to contact your insurance company to obtain your therapy benefits. The benefit information obtained cannot be considered a guarantee of actual benefits or insurance payment for services rendered. We encourage you to contact your insurance company to verify your benefit information.

MEDICARE (if applicable): "I certify that the information given by me in applying for payment under title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries any such information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I understand t I am responsible for any health insurance deductibles and coinsurance."

ASSIGNMENT OF BENEFITS: "I hereby give my health plan lifetime authorization to pay benefits directly to Physical Therapy Associates, Inc. and any assisting physicians for services rendered. I understand that in the event my health plan or healthcare contract does not cover services, I will be responsible for payment. I understand that if my health plan does not consider Physical Therapy Associates, Inc. a participating provider, charges incurred will be paid by me. I further agree to accept full financial responsibility for payment of charges rendered to the above patient."

RETURNED CHECKS: We are happy to accept your personal check, however, if you check is returned to us for any reason, you expressly authorize your account to be electronically debited or bank drafted for the amount of the check plus any applicable fees. The use of a check for payment is your acknowledgement and acceptance of this policy and its terms and conditions.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: "I consent to allow Physical Therapy Associates, Inc. use and disclose my protected health information (PHI) within Physical Therapy Associates, Inc. to carry out my treatment, to obtain payment and to carry out health care operations. My PHI may be disclosed to my health plan and/or its agents as necessary to verify benefits, authorize services, and process medical claims. My PHI may be disclosed to outside health agencies or institutions involved in my continuing care and/or for emergency care purposes. My PHI may include medical information or any information pertaining to the evaluation, treatment and history. This may include psychiatric, HIV/AIDS, sickle cell, alcohol and/or drug information, coded medical information and charges to my health plan and/or their intermediaries. This consent is subject to revocation at any time except to the extent that action has been taken in reliance on it. Withdrawal of consent shall be addressed in writing." By signing below, I hereby authorize Physical Therapy Associates, INC. to receive protected health information about me from the following people.

Name:	Relationship to Patient:

NOTICE OF PRIVACY: "I acknowledge that a copy of the Notice of Privacy Practices is posted in the clinic and available for my review. Furthermore, I understand that I can request, and immediately receive, a copy of this document." The practice will not receive payment from a third party for using or disclosing Personal Health Information

WAIVER AND RELEASE: "I hereby release, discharge and acquit Physical Therapy Associates, Inc., its agents, representatives, affiliates, employees or assigns of and from any and all liability, claim, demand, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and/or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services."

AUTHORIZATION & GUARANTEE:

☐ I acknowledge that I have reviewed, understand and agree to the content & terms described herein.

PATIENT'S RIGHTS AND RESPONSIBILITIES:

☐ I acknowledge I may request to receive a copy of the Patient's Rights and Responsibilities outlined in the Authorization for Use and Disclosure of PHI & the Authorization & Guarantee.

PRIVACY NOTICE:

☐ I acknowledge that I may request to receive a copy of Physical Therapy Associates, Inc. Privacy Practices.

_____ _____

Signature of Patient or Parent/Personal Representative Date

PAST MEDICAL HISTORY

Patient Name (Last, First, MI):	DOB:

Surgery	Date	Doctor

Do you have a history of (please check all that apply):

☐ Arthritis ☐ Asthma ☐ Blood clots ☐ Cancer ☐ Diabetes
☐ High Blood Pressure ☐ Heart Disease ☐ HIV/Aids ☐ Lung Disease ☐ Frequent Falls
☐ Osteoporosis ☐ Seizures ☐ Current Pregnancy

Other pertinent medical conditions? _____

1. Do you have a latex allergy? ☐ Yes ☐ No Adhesive Allergy? ☐ Yes ☐ No

2. Do you have a pacemaker? ☐ Yes ☐ No Defibrillator? ☐ Yes ☐ No

3. Have you received Home Health in the last 60 days? ☐ Yes ☐ No

   If yes, which Home Health Agency? _____ Discharged Date?____/____/20____

4. Have you been treated by a chiropractor and/or physical therapy clinic in the last 12 months? ☐ Yes ☐ No

   If yes, where? _____

5. Have you had any tests (MRI, X-Ray, CT-Scan) of the area you are here for? ☐ Yes ☐ No

   If yes, what type of tests were performed? _____
   and where?_____

6. Rate the severity of your pain: 1 2 3 4 5 6 7 8 9 10
   Mild Hospital Needed

7. When is your next MD appointment? ____/____/20____

8. How did you hear about us? ☐ Family ☐ Friend ☐ Internet ☐ Phone Book ☐ MD ☐ Past Patient

   Please tell us who referred you to our clinic:_____
   If MD, did the MD specifically tell you to attend our clinic?_____

Patient Signature **Parent/Guardian Signature** **Date**
(Required if patient is under 18)

PTA
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Associates, Inc.

ADDITIONAL INFORMATION

Patient Name (Last, First, MI):	DOB:

Is there any other area besides the one listed on your order that causes you pain or discomfort that you would like to discuss with your physical therapist today? Yes No

If yes, what body part?_____

Please provide us with a brief description of symptoms:_____

_____

_____

ATTENTION

OUR THERAPISTS ADVISE

- **2 visits a week is adequate**
- **3 visits a week could get you better faster**

PTA
Physical Therapy
Associates, Inc.

MEDICARE
SECONDARY PAYER
QUESTIONNAIRE

PATIENT NAME:_____ **AGE:**_____

CIRCLE ONE:

1. Is this illness/injury covered by Worker's Compensation? Y N
   If yes, please put employer's or insurer's name, address, and claim number, if available, in #9 below.

2. Is this illness/injury covered under the Federal Black Lung Program? Y N
   If yes, bill should be sent to Federal Black Lung Program, PO Box 828, Lanham-Seabrook, MD 20703-0828.

3. Is this illness/injury the result of an auto accident? Y N
   If yes, enter the responsible auto insurer in #9 below.

4. Is another party's liability insurance responsible for this illness/injury? Y N
   Name of responsible party _____
   Name of liability party _____
   Name of insurer/attorney _____

5. Is this patient covered by any employer group health plan (EGHP), including Federal Employee Health Benefits? Y N
   If no, Medicare is primary. If yes, move to #6 below.

6. Is this patient or his/her spouse actively employed by an employer of 20 or more employees? Y N
   If yes, what is the EGHP date _____. If no, Medicare is primary.

7. Is the patient under age 65 and entitled to Medicare due to a disability? Y N
   If no, move to #8 below. If yes, is the patient or his/her spouse or parent actively employed by an employer of 100 or more employees (LGHP)? If yes, enter the LGHP data in #9 below. If no, Medicare is primary.

8. A Is the patient entitled to Medicare solely on the basis of End Stage Renal Disease (ESRD)? Y N
   If no, move on to question #9 below. If yes, answer question #8b; Medicare is primary.

   B If Yes to 8a, has the patient completed the ESRD coordination period? Y N

9: AUTO INSURER/EMPLOYER:

Name of Insurance Company/Employer:_____

Address:_____

Insured's Name:_____

Policy Number:_____

PTA
Physical Therapy
Associates, Inc.

WHY is it important to see multiple providers during your treatment sessions?

It is a PTA philosophy that the more professionals that see and help with your treatment the better chance PTA has to get you better. This TEAM approach gives you the most complete views from multiple providers for treatment.

IN SHORT

The more professionals from our team that see you the better chances every option available is used to help your recovery

Signature_____