

East Athens Physical Therapy

PATIENT REGISTRATION

Area of Injury to be treated _____ Today's Date _____

Name _____
First MI Last

Address _____
Street PO Box Apt #

Address _____
City State Zip

Home Phone - - - Work Phone - - - Cell Phone - - -

SS# - - - Male or Female Marital Status M S D

Date of Birth _____ E-Mail : _____

How did you hear about us? _____

Emergency Contact: _____ Phone: _____

Employer Information **Occupation** _____

Employer _____

Address _____
Street PO Box Apt #

Address _____
City State Zip

Physician Information

Primary Care Physician Name _____

Address _____
Street City ST Zip

Phone - - - Fax - - -

Would you like notes reflecting your progress at East Athens Physical Therapy sent to your Primary Care Physician?

Yes No

Referring Physician Name _____

Address _____
Street City ST Zip

Phone - - - Fax - - -

Date of your return visit? _____

Have you had physical therapy before? ___ No ___ Yes **If yes, when?** _____

Primary Health Insurance Information

Primary Insured Name _____ Insured Date of Birth _____

Relationship to insured _____ Insured Phone # _____

Insured Address if Different from Patient:

Address _____
Street City ST Zip

Health Insurance Co Name _____ Ins Phone # _____

Address _____
Street City State Zip

Group Number _____ ID Number _____

Contact Name _____

Secondary Health Insurance Information

Primary Insured Name _____ Insured Date of Birth _____

Relationship to insured _____ Insured Phone # _____

Insured Address if Different from Patient:

Address _____

Street City ST Zip
Health Insurance Co Name _____ Ins Phone # _____

Address _____
Street City State Zip

Group Number _____ ID Number _____

Contact Name _____

CONSENT TO TREATMENT

I hereby authorize the professional staff at **East Athens Physical Therapy** to examine and treat me with physical therapy for the injury for which I have been referred.

Patient Signature

Date

Patient Printed Name

Staff Witness Signature

Parent or Guardian Signature (if under 18)

Date

Parent or Guardian Printed Name

Staff Witness Signature

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO HEALTH PROVIDER

Insurance Company/Companies Name(s) _____

I hereby instruct the above named insurance company/companies to pay by check made out to and mailed directly to: East Athens Physical Therapy for professional or medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy. I understand that **East Athens Physical Therapy** complies with HIPPA and will protect my Protected Health Information (PHI) and will use it as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed and full payment is received. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney for the purpose of securing payment under this policy of insurance or to any Medical Provider associated with my case to effectively treat me. The authorization is in effect until 90 days from the date the last bill is collected.

HIPPA REGULATIONS A photocopy of this Assignment shall be considered effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance under the HIPPA guidelines.

Patient Name (Printed) Date

Patient Signature

Parent or Guardian (Printed) Relationship

Parent or Guardian Signature

Witness

Date

**East Athens Physical Therapy
Medical History**

Patient Name _____ Age _____

Type of Injury/Condition _____

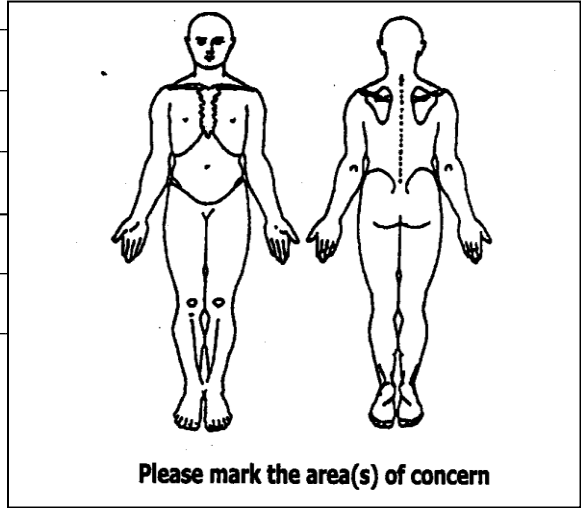
Onset/Injury Date _____

Type of Surgery & Date _____

Next Doctor's Appointment _____

Describe previous treatment for this condition _____

Have you received chiropractic treatment this year? Yes / No



Have you had any imaging performed:

- | | |
|--------------------------------|-------------------------------------|
| <input type="checkbox"/> X-Ray | <input type="checkbox"/> CT Scan |
| <input type="checkbox"/> MRI | <input type="checkbox"/> Doppler |
| | <input type="checkbox"/> Ultrasound |

Have you recently noted:

- | | | |
|---|--|---|
| <input type="checkbox"/> Weight Loss / Gain | <input type="checkbox"/> Nausea / Vomiting | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Fever / Chills / Sweats | <input type="checkbox"/> Numbness / Tingling |
| <input type="checkbox"/> Pregnant / IUD | <input type="checkbox"/> Headaches | <input type="checkbox"/> Change in Vision / Hearing |
| <input type="checkbox"/> Pain at Night | <input type="checkbox"/> Cramps in Legs When Walking | <input type="checkbox"/> Insomnia |

Do you have now or have you ever had any of the following:

- | | | |
|---|--|--|
| <input type="checkbox"/> Surgeries | <input type="checkbox"/> Loss of Consciousness | <input type="checkbox"/> Fractures |
| <input type="checkbox"/> Sprains / Strains | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blood Pressure Problems |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> Motor Vehicle Accident |
| <input type="checkbox"/> Circulation Problems / Clots | <input type="checkbox"/> Asthma / Breathing Problems | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Easy Bruising / Bleeding | <input type="checkbox"/> Leg / Ankle Swelling | <input type="checkbox"/> Urinary Problems / Infections |
| <input type="checkbox"/> Indigestions / Heartburn | <input type="checkbox"/> Fainting | <input type="checkbox"/> Allergies / Skin Sensitivity |
| <input type="checkbox"/> Rheumatoid Arthritis | | |
| <input type="checkbox"/> Any previous injury that may affect current care _____ | | |

Explain and give approximate dates for any items indicated above _____

Are you currently taking medications? Yes / No Name or Type of Medication _____

Type of Pain: Sharp / Burning / Aching / Tingling / Numbness / Other _____

Rate your pain: At its worst: 1 2 3 4 5 6 7 8 9 10 At its best: 1 2 3 4 5 6 7 8 9 10

What do you hope to get out of your treatment? _____

What are your physical or fitness goals? _____

Patient or Personal Representative Signature

Date

East Athens Physical Therapy

We at East Athens Physical Therapy strive to provide our patients with excellent service and quality care. Our commitment to your well-being and health care is something that we take very seriously.

Your commitment to your physical therapy program is critical to your success. We will recommend treatment and set goals for you. In order to reach those goals you must do your part and **your most important part is to make each and every appointment.**

We will give you an appointment card to keep track of your appointments. If you should misplace this, please give us a call to review your appointment dates. We expect you to keep all of your appointments; however, should you need to cancel, please note that we require a 24-hour notice.

If you need to cancel please call our office and reschedule as soon as possible so that we may open up your original time slot to other patients.

If you do not call or show up for your scheduled appointment, you will be charged a \$25.00 “no show” fee.

If you miss 3 consecutive appointments, we will notify your physician and will require a new referral in order to continue your treatment.

Our staff will provide you with as much information regarding your insurance coverage. We will contact your insurance company and verify your physician therapy benefits. We will then let you know what your co-pay, co-insurance, deductible, etc. will be each time you come in for treatment. We encourage you to also call your insurance to find out your coverage and what your financial obligations may be.

Please speak with our Front Desk Specialist if you have any questions regarding your appointments, insurance, financial responsibilities, or any other issues.

Please speak with your therapist if you have any questions regarding your therapy treatment.

We thank you for choosing **East Athens Physical Therapy** and we look forward to working with you and helping you to reach your goals.

The Staff at East Athens Physical Therapy

I have read and understand this policy:

Patient/Guardian

Date