

Achieve Physical Therapy
PATIENT REGISTRATION FORM

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

ADDRESS: _____ APT #: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ EMAIL ADDRESS: _____

SEX: M F BIRTHDATE: _____ AGE: _____ SS #: _____ MARITAL STATUS: _____

EMERGENCY CONTACT: _____ EMERGENCY CONTACT PHONE #: _____

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

EMPLOYER CONTACT: _____

OCCUPATION: _____ WORK PHONE: _____

ACCIDENT RELATED: Y N TYPE: WORK AUTO OTHER

DATE INJURED: _____ HOW INJURY OCCURRED: _____

REFERRING MD: _____ PHONE #: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ GROUP/POLICY#: _____

SECONDARY INSURANCE: _____ GROUP/POLICY # _____

INSURED/RESPONSIBLE PARTY INFORMATION

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

RELATIONSHIP TO PATIENT: SELF SPOUSE CHILD OTHER

BIRTHDATE: _____ AGE: _____ SS#: _____

HOME PHONE: _____ WORK PHONE: _____

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

ATTORNEY/AUTO INSURANCE INFORMATION

ATTORNEY NAME: _____ PHONE #: _____ FAX#: _____

AUTO INSURANCE: _____ PHONE #: _____

ADJUSTER'S NAME: _____ CLAIM #: _____

INSURANCE ASSIGNMENT AND RELEASE

I hereby authorize **Achieve Physical Therapy** to furnish information to the insurance carriers concerning my treatment and hereby assign to the therapist(s) all payments for service rendered. I understand that I am responsible for all charges, even those not paid by my insurance. I understand that by signing I am giving my permission for treatment. I also authorize **Achieve Physical Therapy** to contact the insurance commissioner on my behalf, to assist me in receiving my full insurance benefits, if deemed necessary.

Signature: _____ Date: _____

Receptionist initials: _____

I acknowledge the receipt of Privacy Practice Notice: _____

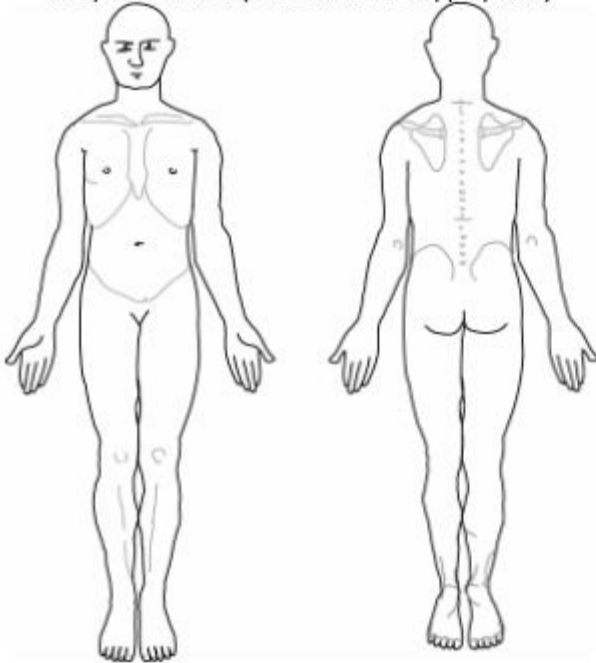
NAME: _____ **DATE:** _____

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

HISTORY OF PRESENT CONDITION

1. What are your symptoms? _____

Localize areas of **pain** or **abnormal** sensation on the body chart below (Shade in where appropriate)



2. When did your symptoms begin?
 (Please indicate a specific date if possible) _____

3. Was the **onset** of this episode gradual or sudden?(Check one)
 (1) gradual (2) sudden

4. Which of the following **best describes** how your injury occurred? (if your condition is post-surgical please indicate as per original injury)

<input type="checkbox"/> (1) lifting	<input type="checkbox"/> (9) a blow to the face
<input type="checkbox"/> (2) a MVA (car accident)	<input type="checkbox"/> (10) being hit by a ball
<input type="checkbox"/> (3) a fall	<input type="checkbox"/> (11) a dental appointment
<input type="checkbox"/> (4) overuse (cumulative trauma)	<input type="checkbox"/> (12) throwing
<input type="checkbox"/> (5) trauma	<input type="checkbox"/> (13) an incident at work
<input type="checkbox"/> (6) degenerative process	<input type="checkbox"/> (14) unknown
<input type="checkbox"/> (7) during recreation/sports	<input type="checkbox"/> (15) other _____
<input type="checkbox"/> (8) running	

5. Since onset, are your symptoms getting: (Check one)
 (1) better (2) worse (3) not changing

6. Have you had similar symptoms in the past? (1) Yes (2) No
 More than one episode? (1) Yes (2) No

7. Nature of pain/symptoms (check all that apply)

<input type="checkbox"/> (1) sharp	<input type="checkbox"/> (4) aching	<input type="checkbox"/> (7) constant
<input type="checkbox"/> (2) dull	<input type="checkbox"/> (5) periodic	<input type="checkbox"/> (8) other _____
<input type="checkbox"/> (3) throbbing	<input type="checkbox"/> (6) occasional	

8. As the day progresses, do your symptoms: (Check one)
 (1) increase (2) decrease (3) stay the same

9. Does the pain wake you at night? (1) No (2) Yes
 if "yes", is it present (1) while lying still
 (2) only when changing positions
 (3) both

10. Do you have pain/stiffness upon getting out of bed in the morning? (1) Yes (2) No

11. In what position do you sleep? (Check all that apply)

<input type="checkbox"/> (1) right side	<input type="checkbox"/> (4) back	<input type="checkbox"/> (6) back, sides, stomach
<input type="checkbox"/> (2) left side	<input type="checkbox"/> (5) chair/recliner	<input type="checkbox"/> (7) other _____
<input type="checkbox"/> (3) stomach		

12. Since the onset of your current symptoms have you had:

- (1) any difficulty with control of bowel or bladder function
- (2) fever/Chills
- (3) any numbness in the genital or anal area
- (4) numbness
- (5) any dizziness or fainting attacks
- (6) weakness
- (7) unexplained weight change
- (8) night pain/sweats
- (9) malaise (vague feeling of bodily discomfort)
- (10) problems with vision/hearing
- (11) none of the above

13. What aggravates your symptoms? (Check all that apply)

<input type="checkbox"/> (1) sitting	<input type="checkbox"/> (9) repetitive activities
<input type="checkbox"/> (2) going to/rising from sitting	including _____
<input type="checkbox"/> (3) lying down	<input type="checkbox"/> (10) household activities
<input type="checkbox"/> (4) walking	including _____
<input type="checkbox"/> (5) up/down stairs	<input type="checkbox"/> (11) standing
<input type="checkbox"/> (6) reaching overhead	<input type="checkbox"/> (12) squatting
<input type="checkbox"/> (6) reaching in front of body	<input type="checkbox"/> (13) sleeping
<input type="checkbox"/> (6) reaching behind back	<input type="checkbox"/> (14) coughing/sneezing
<input type="checkbox"/> (6) reaching across body	<input type="checkbox"/> (15) taking a deep breath
<input type="checkbox"/> (7) talking, chewing, yawning, all (circle one)	<input type="checkbox"/> (16) looking up overhead
<input type="checkbox"/> (8) recreation/sports including _____	<input type="checkbox"/> (17) swallowing
	<input type="checkbox"/> (18) stress
	<input type="checkbox"/> (19) sustained bending
	<input type="checkbox"/> (20) other _____

14. What relieves your symptoms? (Check all that apply)

<input type="checkbox"/> (1) sitting	<input type="checkbox"/> (6) rest	<input type="checkbox"/> (11) massage
<input type="checkbox"/> (2) heat	<input type="checkbox"/> (7) standing	<input type="checkbox"/> (12) medication
<input type="checkbox"/> (3) cold	<input type="checkbox"/> (8) walking	<input type="checkbox"/> (13) nothing
<input type="checkbox"/> (4) stretching	<input type="checkbox"/> (9) exercise	<input type="checkbox"/> (14) other _____
<input type="checkbox"/> (5) wearing a splint/orthosis	<input type="checkbox"/> (10) lying down	

15. Have you had any previous treatment for this condition?
(Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> (1) none | <input type="checkbox"/> (11) hypnosis |
| <input type="checkbox"/> (2) medication (oral) | <input type="checkbox"/> (12) biofeedback |
| <input type="checkbox"/> (3) joint manipulation | <input type="checkbox"/> (13) TENS unit |
| <input type="checkbox"/> (4) exercise | <input type="checkbox"/> (14) acupuncture |
| <input type="checkbox"/> (5) massage therapy | <input type="checkbox"/> (15) bed rest |
| <input type="checkbox"/> (6) traction | <input type="checkbox"/> (16) overnight hospitalization |
| <input type="checkbox"/> (7) bracing/taping | <input type="checkbox"/> (17) casting |
| <input type="checkbox"/> (8) injection into the spine | <input type="checkbox"/> (18) other _____ |
| <input type="checkbox"/> (9) injection into the skin/muscles | |
| <input type="checkbox"/> (10) physical therapy | |

16. Have you had any of the following tests?

- | | |
|--|---|
| <input type="checkbox"/> (1) none | <input type="checkbox"/> (7) Bone Scan |
| <input type="checkbox"/> (2) x-rays | <input type="checkbox"/> (8) NCS |
| <input type="checkbox"/> (3) CT Scan | <input type="checkbox"/> (9) Fluoroscope |
| <input type="checkbox"/> (4) MRI | <input type="checkbox"/> (10) Vestibular |
| <input type="checkbox"/> (5) Arthrogram | <input type="checkbox"/> (11) other _____ |
| <input type="checkbox"/> (6) Stress X-ray Test (Telos) | |
- Test Results: _____

MEDICATION

Please list any prescription medications you are currently taking
(*pain pills, injections and/or skin patches, etc.*):

Prescribing MD: _____ Phone: _____

Are you currently taking any of the following over the counter medications?

- | | |
|---|---|
| <input type="checkbox"/> (1) aspirin | <input type="checkbox"/> (6) Advil/Motrin/
Ibuprofen |
| <input type="checkbox"/> (2) Tylenol | <input type="checkbox"/> (7) other _____ |
| <input type="checkbox"/> (3) corticosteroids | |
| <input type="checkbox"/> (4) antihistamines | |
| <input type="checkbox"/> (5) vitamins/mineral supplements | |

PREVIOUS FUNCTIONAL LEVEL

Independent in all activities (work, community, home, recreation)

Self-care

- Independent in all self-care activities (bathing, toileting, dressing, etc.)
- Difficulty performing self-care activities
- Need assistance with self-care activities
- Difficulty performing household chores

Social

- Need assistance with activities in community outside of home

Hobbies:

WORK HISTORY

Occupation

- | | |
|---|--|
| <input type="checkbox"/> (1) employed full time | <input type="checkbox"/> (5) student |
| <input type="checkbox"/> (2) employed part time | <input type="checkbox"/> (6) retired |
| <input type="checkbox"/> (3) self employed | <input type="checkbox"/> (7) unemployed |
| <input type="checkbox"/> (4) homemaker | <input type="checkbox"/> (8) other _____ |

Physical activities at work (check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> (1) sitting | <input type="checkbox"/> (6) computer use |
| <input type="checkbox"/> (2) standing | <input type="checkbox"/> (7) heavy equipment operation |
| <input type="checkbox"/> (3) phone use | <input type="checkbox"/> (8) driving |
| <input type="checkbox"/> (4) repetitive lifting | <input type="checkbox"/> (9) other _____ |
| <input type="checkbox"/> (5) heavy lifting | |

Are you currently receiving or seeking disability for this condition? (1) Yes (2) No

If not performing your normal activities at work do you plan to RETURN to your previous activity level?

- (1) Yes (2) No

LIVING SITUATION

- | | |
|--|--|
| <input type="checkbox"/> (1) live alone | <input type="checkbox"/> (6) assisted living complex |
| <input type="checkbox"/> (2) live with family members/others | <input type="checkbox"/> (7) other _____ |
| <input type="checkbox"/> (3) live with caregiver | |
| <input type="checkbox"/> (4) home/apartment | |
| <input type="checkbox"/> (5) retirement complex (SNF/ICF) | |

Setting

- | | | |
|--|--|--|
| <input type="checkbox"/> (1) stairs (railing) | <input type="checkbox"/> (3) no stairs | <input type="checkbox"/> (6) uneven ground |
| <input type="checkbox"/> (2) stairs (no railing) | <input type="checkbox"/> (4) ramp | <input type="checkbox"/> (7) other _____ |
| | <input type="checkbox"/> (5) elevator | |

GENERAL HEALTH

How would you rate your general health?

- | | | |
|------------------------------------|----------------------------------|-------------------------------|
| <input type="checkbox"/> Excellent | <input type="checkbox"/> Average | <input type="checkbox"/> Poor |
| <input type="checkbox"/> Good | <input type="checkbox"/> Fair | |

Do you exercise outside of normal daily activities?

- | | | |
|--------------------------------------|---------------------------------------|-------------------------------|
| <input type="checkbox"/> 5+ days/wk | <input type="checkbox"/> 1-2 days/wk | <input type="checkbox"/> zero |
| <input type="checkbox"/> 3-4 days/wk | <input type="checkbox"/> occasionally | |

Exercise, Sports/Recreation consisting of _____

Do you drink caffeinated beverages?

- No Yes How many/much per day _____

Do you smoke?

- No Yes Packs of cigarettes per day _____

What is your stress level?

- Low Medium High

Are you seeing any health care providers other than the physical therapist for this current condition? (Please list) _____

PAST MEDICAL HISTORY

Have you ever had/been diagnosed with any of the following conditions? (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Cancer (type) _____ | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> Depression | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Lung problems |
| <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Blood disorders |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Epilepsy/seizures |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Broken bone |
| <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Circulation/vascular problems |
| <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Infectious diseases (i.e. hepatitis, tuberculosis, etc.) | |

Please list any recent/relevant past surgeries related to your current problem:

SURGERY _____ **DATE** _____

FAMILY HISTORY

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

- | | |
|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Psychological condition |
| <input type="checkbox"/> Other _____ | |

ACHIEVE PHYSICAL THERAPY AND SPORTS TRAINING
NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

ACHIEVE PHYSICAL THERAPY'S LEGAL DUTY

Achieve Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Achieve Physical Therapy uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Achieve Physical Therapy may use your personal health information for the following purposes:

- We will use your health information for treatment For example: Information obtained will be recorded in your records and use to determine the course of treatment that should work best for you. We will also provide your referring physician or appropriate health care provider with copies of reports/summaries that should assist him or her in assessing your plan of care.
- We will use your health information for payment For example: A bill may be sent to you or a third party payor. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.
- We will use your health information for regular health operations For example: Members of our organization may use information in your health record to assess the care and outcomes in your case and other like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and services we provide.

OTHER FORMS OF DISCLOSURES

- Business Associates: There are some services provided in our organization that utilize outside agencies. These include medical supply companies and other forms of business associates that provide us a service. To protect your health information we require each of our business associates to sign a contract with our organization stating they will safeguard your information.
- Notification: We may use or disclose information to notify or assist in notifying a family member, personal representatives or another person responsible for your care, location and general condition.
- Communication with Family: We may disclose to a family member, other relative, close personal friend or any other person you identify health information relevant to that person's involvement in your care or payment related to your care.
- Marketing: We may contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.
- Federal and State Agencies: As required by law we may disclose health information to public health or legal authorities charge with preventing or controlling diseases, injury or disability.
- Law Enforcement: As required by law we may disclose health information for law enforcement purposes as required by law or in response to valid subpoena.

In any other situation, Achieve Physical Therapy's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Achieve Physical Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and/or patient exam areas, on our website, and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Achieve Physical Therapy will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Achieve Physical Therapy may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our patient representative. You may also send a written complaint to the US Department of Health and Human Services. For further information on Achieve Physical Therapy's health information practices or if you have a complaint, please contact our patient representative.

Achieve Physical Therapy Patient Attendance Policy

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well being and gain of your physical abilities is something everyone in our clinic takes quite seriously. We realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care that you need to receive and to the actions we ask you to do.

Your adherence to the recommended number of treatments is a vital component of your progress with our services. We have certain rules that need to be followed in order to ensure the most optimum results.

1. It is expected that you keep **all** your scheduled appointments with APT.
2. **24 hours notice is required for an appointment to be rescheduled.** In such a case, please call our office and arrange for a make-up appointment with our Front Desk Receptionist. This appointment needs to be in the same week of the original appointment, preferably the very next day.
3. In an instance of a **cancellation without 24 hours notice or no-show** to a scheduled appointment, we reserve the right to charge a **\$50.00 fee.***
4. With **three consecutive** "no-shows" and/or cancellations, we reserve the right to discontinue care and to inform your physician of discontinuation of care due to non-compliance with the prescribed rehabilitation order.

*The only exception to the cancellation fee is in the case of an emergency.

We greatly appreciate you as a patient. We strive to achieve wonderful results and success as a team with you.

I certify that I have read and understand the above APT attendance policy:

Print Name: _____ **Date:** _____

Signature: _____ **Date:** _____

Achieve Physical Therapy Our Financial Policy

- A. METHOD OF PAYMENT – All patients are expected to pay in cash, check or credit card (**VISA/MC** are accepted) the day the service is rendered, unless specific arrangements are made in advance.
- B. INSURANCE INFORMATION – For those patients covered by insurance, we will accept assignment of benefits. Most policies do not cover 100% of the cost of your treatment. As a courtesy we verify and file claims to your insurance company. **WE DO NOT GUARANTEE PAYMENT.** If you do not inform us of your current insurance, or fail to provide the insurance company with updated information, you voluntarily waive your rights to use your insurance with Achieve Physical Therapy at any time.
- C. CO-PAYS, DEDUCTIBLES & BALANCES - You will be asked to pay your deductible and your portion of your charges (Co-pay) the day the service is rendered. We will estimate, as closely as possible, your coverage, but until we actually receive the payment from the insurance company, it is just an **estimate**. Additionally, you are responsible for any outstanding balance due to Achieve Physical Therapy.
- D. MEDICARE PATIENT CAP – For the calendar year of 2010, the cap for Medicare is **\$1860.00**.
- E. MEDICARE PATIENTS W/O SECONDARY OR SUPPLEMENTAL INSURANCE
We have estimated a **\$25.00** co-insurance for patients that do not have secondary or supplemental insurance.
- F. AGREEMENT OF FINANCIAL RESPONSIBILITY – All expenses incurred by Achieve Physical Therapy in the collection of delinquent balances are your responsibility. Including the following:
- Return Check Fees
 - Attorney's Fees
 - Court Costs
 - Filing Fees
 - Collection Agency Charges and Commission Fees
 - Collection Fees will be **40% for regular** collections and **50% for legal** collections or forwards, which may be as much as twice the original principal balance owed.
 - Interest Rate of 2% per month, 24% per year from 1st date of delinquency

AGREEMENT OF FINANCIAL RESPONSIBILITY – I have read the above. I understand that I will be financially responsible for all outstanding charges not paid by my insurance company.

Patient's Signature: _____ Date: _____

Parent Signature (if Minor): _____ Date: _____

Achieve Therapy Employee
Initials: _____ Date: _____