



PATIENT REGISTRATION

NAME FIRST MI LAST DATE OF BIRTH

ADDRESS STREET CITY STATE ZIP

PHONE INFO: HOME WORK MOBILE BEST WAY TO CONFIRM APPOINTMENTS CALL TEXT EMAIL (TEXT) MOBILE CARRIER

EMAIL ADDRESS

MALE FEMALE MARITAL STATUS: MARRIED SINGLE WIDOWED DIVORCED

IF YOU ARE A MINOR, GUARDIAN NAME RELATION

EMERGENCY CONTACT:

NAME PHONE RELATION

WHO CAN WE SHARE OR DISCUSS YOUR HEALTH INFORMATION WITH?

EMPLOYMENT INFORMATION

FULL-TIME PART-TIME RETIRED LIGHT DUTY SINCE OUT OF WORK SINCE

EMPLOYER

ADDRESS STREET CITY STATE ZIP

HEALTH INSURANCE INFORMATION

PRIMARY ID# GROUP #

SUBSCRIBER DATE OF BIRTH RELATION

PHONE # SUBSCRIBER EMPLOYER

SECONDARY ID# GROUP #

SUBSCRIBER DATE OF BIRTH RELATION

PHONE # SUBSCRIBER EMPLOYER

REFERRAL INFORMATION

REFERRING PHYSICIAN PHONE #

ADDRESS STREET CITY STATE ZIP

PRIMARY CARE PHYSICIAN PHONE #

ADDRESS STREET CITY STATE ZIP

HAVE YOU HAD PHYSICAL THERAPY FOR ANY PREVIOUS PROBLEMS? YES NO IF YES, WHEN?

PLEASE BE SURE TO COMPLETE THE OTHER SIDE OF THIS FORM ->

AUTO INJURIES, WORK INJURIES and PERSONAL INJURIES ONLY – please complete the following section:

INJURY DATE _____ INJURY TYPE: WORK AUTO SLIP / FALL OTHER

IF WORK RELATED, DID YOU REPORT THIS TO YOUR EMPLOYER? YES NO CLAIM # _____

IF AN AUTO ACCIDENT, IN WHAT STATE DID THE ACCIDENT OCCUR? _____

HAVE YOU FILED A CLAIM FOR THIS INJURY YES NO CLAIM # _____

INSURANCE COMPANY _____ PHONE _____

ADDRESS _____ CONTACT PERSON _____

DO YOU HAVE AN ATTORNEY YES NO NAME _____

ADDRESS _____ PHONE _____

APPOINTMENT ATTENDANCE POLICY - ALL PATIENTS PLEASE READ

- We are here to help you through a successful rehabilitation process. To speed your recovery, we strongly recommend that you attend all of your scheduled therapy sessions.
- If you are unable to attend an appointment, please let us know 24-hours in advance so we can offer your treatment time to another patient and get your appointment rescheduled to another time.
- Please understand that when an appointment is not kept and proper notice is not given, three people are affected adversely:
 1. You - because you are not receiving the treatment you need.
 2. Your therapist - as their time had been reserved for you personally.
 3. Another patient - who could have been scheduled for treatment, if proper notice had been given.
- There will be a \$25.00 charge for canceling an appointment with less than a 24-hour notice and/or for not showing for an appointment.
- If you do not show for two or more appointments:
 1. We will notify the referring doctor that you are not attending your scheduled sessions.
 2. Your employer will be notified if a workers compensation carrier is responsible for payment.
 3. We reserve the right to remove all of your future appointments from the schedule and we may require that you obtain a new referral from your physician to re-start treatment.

CONSENT TO TREAT

I, the undersigned, hereby voluntarily authorize Specht Physical Therapy to perform outpatient diagnostic evaluation and/or procedures and to administer such outpatient therapy that is necessary and appropriate. I understand that physical therapy is not an exact science and no guarantee has been made as to the result of any treatment or care administered.

AUTHORIZATION TO RELEASE INFORMATION

I, the undersigned, hereby authorize Specht Physical Therapy and the attending therapist to release information relative to any outpatient therapy treatment administered, to any third-party payor(s) financially responsible for these services, to my referring physician and to my primary care physician, in regards to my physical therapy diagnosis and treatments.

ACKNOWLEDGEMENT OF TERMS

By signing below, I attest that all information given is true and accurate to the best of my ability and that I have read and understand the policies stated above.

PATIENT SIGNATURE: _____ DATE _____

WITNESS SIGNATURE: _____ DATE _____

SPECHT PHYSICAL THERAPY FINANCIAL POLICY

To Our Valued Patients:

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at each visit for charges incurred up through your last visit.

We accept cash, checks, MasterCard, Visa, American Express and Discover. We bill electronically, to expedite payment of claims.

Please read carefully:

1. Physical therapy services are reimbursed under the provisions of most health insurance policies. As the subscriber, you are primarily responsible for knowing the terms of your policy. While we will take care of filing insurance claims on your behalf, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.
2. Your deductible is the amount that you pay for medical costs before your health insurance begins paying for your care. If you have a deductible, and it has not been met for the plan year, you must pay the full allowable amount (based on your insurance company's payment schedule) for each of your treatment sessions until the deductible amount has been reached.
3. Medicare patients are responsible for the yearly deductible on their secondary insurance and if Medicare is the only insurance they are responsible for 20% of treatment fees.
4. If your injury is work related, a Workers Compensation claim must be initiated. If your case is denied by workers comp, then you are responsible for each visit. We require that you provide us with your medical insurance to insure payment of the account if your case is not allowed. If you already have a claim number, please provide us with the number on the registration form. If you have an attorney, please provide this information on the registration form.
5. Liability cases (i.e. motor vehicle accident, slip and fall, etc.) are accepted when accompanied by a health insurance plan and/or auto insurance with medical payments (medpay). When another party is responsible, you must provide us with all the billing information. If you have an attorney, please provide their information on the registration form. It is this office's policy that a letter of protection, also known as a lien must be received from your attorney within the first week of your treatment. Without this letter, you become responsible for the account in full. Also please provide your attorney with our information and let them know that you are receiving treatment at our facility.

OVER →

6. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are generally covered up to the maximum allowance determined by each carrier. If you (the subscriber) should receive a check from your insurance company that is intended for this practice (the provider) for services rendered, you should immediately remit this to our office for credit to your account. Failure to do so will result in our office billing you for the complete balance and you will be responsible for payment of this amount in full.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you!

I fully understand the contents of your office policies and procedures and agree to abide by them. I also understand and agree to pay for the charges that may be incurred for physical therapy services rendered by this office, consistent with the terms of my health insurance policy. I have read the above policy and agree.

PRINT NAME : _____

SIGNATURE: _____ DATE: _____

As a courtesy to our patients we contact your insurance company in order to provide information about your physical therapy benefits, deductibles and co-payments. The information provided below is an estimate and may differ from your actual benefits (including coverage, co-payment and deductible amount). We encourage you to call the customer service number on the back of your insurance card to obtain the most accurate information about your insurance benefits.

Subscriber Insurance Information (Estimated):

Annual Deductible \$ _____ Deductible Not Yet Met \$ _____

Copay \$ _____ / visit Coinsurance _____ % or approx \$ _____ / visit

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received the Notice of Privacy Practices from Specht Physical Therapy.

Signature: _____ Date: _____

OFFICE USE ONLY

In lieu of patient signature, I, _____, a staff member of Specht Physical Therapy, state that _____ has been given our current Notice of Privacy Practices.

Signature: _____ Date: _____

SPECHT PHYSICAL THERAPY MEDICAL HISTORY FORM

PATIENT INFORMATION		PHYSICIAN INFORMATION	
Patient Name:		Primary Physician:	
Date: / /	Age:	Referring Physician:	

CURRENT INJURY	
Body part(s) to be treated:	
Onset: Sudden <input type="checkbox"/> Gradual <input type="checkbox"/> Date of injury <i>OR</i> Duration of symptoms:	
If you had an injury, <u>briefly</u> describe how the injury occurred:	
Have you had a similar symptoms before: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Who have you seen for your current condition: Primary MD <input type="checkbox"/> Orthopedic MD <input type="checkbox"/> Other MD <input type="checkbox"/> PT <input type="checkbox"/> Chiropractor <input type="checkbox"/>	
What Tests or Procedures have been done for your current condition: X-Rays <input type="checkbox"/> MRI/CT Scan <input type="checkbox"/> Bone Scan <input type="checkbox"/> EMG <input type="checkbox"/> Blood Work <input type="checkbox"/> Other <input type="checkbox"/>	
What Treatment has been performed for your current condition: No Treatment <input type="checkbox"/> Medication <input type="checkbox"/> Injection(s) <input type="checkbox"/> PT <input type="checkbox"/> Surgery <input type="checkbox"/> date: / /	
What medications are you taking for your current condition (prescribed or over the counter):	
1) _____ 2) _____ 3) _____ 4) _____	
What was your <u>primary</u> reason for choosing Specht.PT:	
<input type="checkbox"/> Doctor highly recommended <input type="checkbox"/> On doctor's list of clinics <input type="checkbox"/> Family/Friend <input type="checkbox"/> Insurance In-Network <input type="checkbox"/> Convenient location <input type="checkbox"/> Website/On-line review	

OCCUPATION	
What is your occupation: _____	<input type="checkbox"/> Homemaker <input type="checkbox"/> Retired <input type="checkbox"/> Student
Are you currently employed (excluding homemaker): Yes <input type="checkbox"/> No <input type="checkbox"/> <i>if yes</i> F/T <input type="checkbox"/> P/T <input type="checkbox"/>	
My work primarily involves: Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor <input type="checkbox"/>	

HOBBIES OR LEISURE ACTIVITIES <i>(please list any physical hobbies or leisure activities)</i>

GENERAL FITNESS LEVEL
How would you describe your current fitness level: Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/>
How often do you exercise weekly: None <input type="checkbox"/> 1-2x <input type="checkbox"/> 3-4x <input type="checkbox"/> 5+ <input type="checkbox"/>
General stress level: Low <input type="checkbox"/> Moderate <input type="checkbox"/> High <input type="checkbox"/> Overwhelmed, feeling hopeless <input type="checkbox"/>

(Continued on Reverse)

PAST MEDICAL HISTORY (Please check “yes” if you have ever been diagnosed with...)

Note: If you are unsure about a particular item, please leave it blank and discuss this with your therapist

	Yes	No		Yes	No
Systemic Disorders			Neurologic		
Systemic Arthritis (RA, Lupus, Other)	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained rashes, sores or swelling	<input type="checkbox"/>	<input type="checkbox"/>	MS/Parkinsons	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia/ Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>
			Poor balance with frequent falls	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorders			Recent tremors or clumsy walking	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/tingling both hands or feet	<input type="checkbox"/>	<input type="checkbox"/>
Clotting disorders	<input type="checkbox"/>	<input type="checkbox"/>			
History DVT (Blood Clots)	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary		
Currently taking blood thinners	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Peripheral vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath with exercise	<input type="checkbox"/>	<input type="checkbox"/>
			Require the use of an inhaler	<input type="checkbox"/>	<input type="checkbox"/>
Cancer			Other		
History of cancer, any type	<input type="checkbox"/>	<input type="checkbox"/>	Currently pregnant (or think you might be)	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular			Do you have a pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Do you have metal implants	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain or Angina	<input type="checkbox"/>	<input type="checkbox"/>	Severe cold intolerance/Raynauds	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Poor tolerance to NSAID's	<input type="checkbox"/>	<input type="checkbox"/>
Heart rate restrictions w/ ex. (per MD)	<input type="checkbox"/>	<input type="checkbox"/>	Severe food or drug allergies	<input type="checkbox"/>	<input type="checkbox"/>
			Vision or hearing difficulties	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine/Metabolic			Constitutional symptoms (Current)		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Fever/ chills/ nights sweats	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Severe fatigue/malaise	<input type="checkbox"/>	<input type="checkbox"/>
Immunologic			Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/fainting	<input type="checkbox"/>	<input type="checkbox"/>
HEP B, HEP C	<input type="checkbox"/>	<input type="checkbox"/>	Unexplained weight loss, >10% BW	<input type="checkbox"/>	<input type="checkbox"/>

Other: please include recent hospitalizations or any other information that you think would be beneficial in helping us with your care:

To the best of my knowledge, the information above is accurate.

Signature: _____

Date: _____

Relationship to Patient: _____