PATIENT REGISTRATION

NAME ______________________________ DATE OF BIRTH ______________
FIRST MI LAST

ADDRESS ____
STREET CITY STATE ZIP

PHONE INFO: HOME ______________________________ ❑ **BEST WAY TO CONFIRM APPOINTMENTS**

WORK ______________________________ ❑ ❑ CALL ❑ TEXT ❑ EMAIL

MOBILE ______________________________ ❑ (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

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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 ☐ Gradual ☐	Date of injury *OR* Duration of symptoms:
If you had an injury, briefly describe how the injury occurred:	
Have you had a similar symptoms before: Yes ☐ No ☐	
Who have you seen for your current condition: Primary MD ☐ Orthopedic MD ☐ Other MD ☐ PT ☐ Chiropractor ☐	
What Tests or Procedures have been done for your current condition: X-Rays ☐ MRI/CT Scan ☐ Bone Scan ☐ EMG ☐ Blood Work ☐ Other ☐	
What Treatment has been performed for your current condition: No Treatment ☐ Medication ☐ Injection(s) ☐ PT ☐ Surgery ☐ date: / /	
What medications are you taking for your current condition (prescribed or over the counter): 1)____________________2)____________________3)____________________ 4)____________________	
What was your primary reason for choosing Specht.PT: ☐ Doctor highly recommended ☐ On doctor's list of clinics ☐ Family/Friend ☐ Insurance In-Network ☐ Convenient location ☐ Website/On-line review	

OCCUPATION
What is your occupation:____ OR ☐ Homemaker ☐ Retired ☐ Student
Are you currently employed (excluding homemaker): Yes ☐ No ☐ *if yes* F/T ☐ P/T ☐
My work primarily involves: Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor ☐

HOBBIES OR LEISURE ACTIVITIES *(please list any physical hobbies or leisure activities)*

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

(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
Systemic Disorders		
Systemic Arthritis (RA, Lupus, Other)	☐	☐
Unexplained rashes, sores or swelling	☐	☐
Fibromyalgia/ Chronic Fatigue	☐	☐
Blood Disorders		
Bleeding disorders	☐	☐
Clotting disorders	☐	☐
History DVT (Blood Clots)	☐	☐
Currently taking blood thinners	☐	☐
Peripheral vascular disease	☐	☐
Cancer		
History of cancer, any type	☐	☐
Cardiovascular		
Heart Attack	☐	☐
Chest pain or Angina	☐	☐
Fainting	☐	☐
Heart rate restrictions w/ ex. (per MD)	☐	☐
Endocrine/Metabolic		
Diabetes	☐	☐
Osteoporosis	☐	☐
Immunologic		
HIV	☐	☐
HEP B, HEP C	☐	☐

	Yes	No
Neurologic		
Stroke/TIA	☐	☐
MS/Parkinsons	☐	☐
Seizure disorder	☐	☐
Poor balance with frequent falls	☐	☐
Recent tremors or clumsy walking	☐	☐
Numbness/tingling both hands or feet	☐	☐
Pulmonary		
Asthma	☐	☐
Shortness of breath with exercise	☐	☐
Require the use of an inhaler	☐	☐
Other		
Currently pregnant (or think you might be)	☐	☐
Do you have a pacemaker	☐	☐
Do you have metal implants	☐	☐
Severe cold intolerance/Raynauds	☐	☐
Poor tolerance to NSAID's	☐	☐
Severe food or drug allergies	☐	☐
Vision or hearing difficulties	☐	☐
Constitutional symptoms (Current)		
Fever/ chills/ nights sweats	☐	☐
Severe fatigue/malaise	☐	☐
Nausea/vomiting	☐	☐
Dizziness/fainting	☐	☐
Unexplained weight loss, >10% BW	☐	☐

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:____________________________