SPECHT PHYSICAL THERAPY

PATIENT REGISTRATION

NAME _____ DOB _____ ❑ MALE ❑ FEMALE
FIRST LAST

ADDRESS _____
STREET CITY STATE ZIP

MOBILE _____ ❑

HOME _____ ❑

EMAIL _____ ❑

WHAT IS THE BEST WAY TO CONFIRM APPOINTMENTS? CHECK BOXES TO LEFT & BELOW

❑ TEXT ❑ CALL ❑ EMAIL

EMERGENCY CONTACT:

NAME _____ PHONE _____ RELATION _____

IS THERE ANYONE WE SHOULD SHARE OR DISCUSS YOUR HEALTH INFORMATION WITH? ❑ YES ❑ NO

IF YES, PLEASE PROVIDE THEIR INFORMATION _____

HAVE YOU HAD PHYSICAL THERAPY OR HOME CARE FOR ANY PREVIOUS CONDITION? ❑ YES ❑ NO

IF YES, PLEASE PROVIDE APPROXIMATE DATES _____

IS YOUR CURRENT CONDITION THE RESULT OF AN AUTO, WORK OR PERSONAL INJURY? ❑ YES ❑ NO

HEALTH INSURANCE INFORMATION

PRIMARY_____ ID# _____GROUP # _____

SUBSCRIBER _____ DATE OF BIRTH _____ RELATION _____

SECONDARY_____ ID# _____GROUP # _____

SUBSCRIBER _____ DATE OF BIRTH _____ RELATION _____

REFERRAL INFORMATION

PRIMARY CARE PHYSICIAN _____ PHONE # _____

ADDRESS _____
STREET CITY STATE ZIP

REFERRING PHYSICIAN _____ PHONE # _____

ADDRESS _____
STREET CITY STATE ZIP

OFFICE USE ONLY ID#_____PT_____ POST/OP_____ DIA_____CC_____ S/A_____ CHECK_____

APPOINTMENT ATTENDANCE POLICY

- To accelerate your recovery, we strongly recommend that you attend all 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 reschedule your appointment.
- When an appointment is not kept and proper notice is not given, three people are affected:
    1. You – because you are not receiving the treatment you need.
    2. Your physical therapist – as their time had been reserved for you personally.
    3. Another patient – who could have been seen if proper notice had been given.
- There will be a **$60.00** charge for canceling an appointment with less than a 24-hour notice or for not showing for an appointment.
- If you do not show for two or more appointments, we reserve the right to cancel your future appointments.

Patient or Guardian Signature _____ Date _____

CONSENT TO TREAT

I, the undersigned, hereby voluntarily authorize Specht Physical Therapy clinicians to perform outpatient diagnostic evaluation and/or procedures and to administer such outpatient therapy that is deemed 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.

Patient or Guardian Signature _____ Date _____

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.

Patient or Guardian Signature _____ Date _____

HIPAA - PRIVACY PRACTICES ACKNOWLEDGEMENT

*Before signing below, be sure to read and fully understand our Notice of Privacy Practices which is on our website at **www.spechtphysicaltherapy.com/hipaa** or a printed copy will be provided to you. Please let us know if you would like additional information or you may request a copy for your records.*

By signing below, I acknowledge that I, _____ have reviewed the Notice of Privacy Practices from Specht Physical Therapy

Patient or Guardian Signature _____ Date _____

FINANCIAL POLICY

*Before signing below, be sure to read and fully understand our Financial Policy which is on our website at **www.spechtphysicaltherapy.com/financial** or a printed copy will be provided to you. Please let us know if you would like additional information or you may request a copy for your records.*

By signing below, I acknowledge that I have reviewed the Specht Physical Therapy Financial Policy.

Patient or Guardian Signature _____ Date _____

SPECHT PHYSICAL THERAPY

Name_____ DOB_____ Age: ____
Who can we thank for referring you to Specht PT? _____
Height: _____ Weight:_____ Preferred Pronouns (optional) _____

Have you EVER been diagnosed with any of the following conditions? (check all that apply)

__Cancer
__Diabetes I or II
__Stroke
__Blood Clot
__Pacemaker
__Depression
__Seizures
__Ulcers
__High Blood Pressure
__Heart Disease
__Liver Disease
__Kidney Disease
__Lung Disease
__Asthma
__Fibromyalgia
__Osteoporosis
__Rheumatoid Arthritis
__Concussion
__Fracture
__Latex allergy
__Other_____

Do you: Have a family history of heart disease? __Yes __No **Smoke cigarettes?** __Yes __No

Have you RECENTLY experienced any of the below? (check all that apply)

__General malaise, fatigue, or lacking energy?
__Trauma (e.g., motor vehicle accident or fall)?
__Difficulty maintaining balance when walking?
__Cramping in your legs when you walk?
__Use of corticosteroids (e.g., prednisone)?
__Changes in bowel or bladder function?
__Constipation?
__Increased or decreased pain with meals?
__Unusual pain or changes with menstruation?
__Weakness in your arms or legs?
__Swelling in your legs?
__Increased pain at night/rest?
__Dizziness or Light-headedness?
__Fever/Chills/Sweats?
__Women: Pregnancy or possible pregnancy
__Weight loss or gain?
__Difficulty swallowing?
__Difficulty speaking?
__Abdominal pain?
__Vision changes?
__Numbness or Tingling?
__Nausea or Vomiting?
__Chest Pain?
__Shortness of breath?
__Changes in appetite?
__Easy bruising?
__Headaches?
__Cholesterol level greater than 200 mg/dl
__Blood Glucose (fasting) greater than 100 mg/dl
__Other _____

During the past month:

Have you felt down, depressed or hopeless? __Yes __No
Have you had little interest or pleasure in doing things? __Yes __No
If YES, is this something with which you would like help? __Yes __Yes, but not today __No

Have you ever had pain, injury, or surgery in any of the below regions? (check all that apply)

__Back __Neck __Shoulder __Knee __Hip __Foot __Ankle __Other _____

Past Surgical History (please include dates if known):

_____
_____

Current Medications (please list or provide a list to photocopy):

_____
_____