PATIENT REGISTRATION

PLEASE COMPLETE ALL SECTIONS			
NAME		HOME PHONE	CELL PHONE
ADDRESS		CITY, STATE	ZIP CODE
EMPLOYER		WORK PHONE	
BIRTH DATE	SEX	EMAIL	
MARITAL STATUS		PRIMARY CARE PHYSICIAN	
SOCIAL SECURITY NUMBER		PREFERRED METHOD OF CONTACT?	
EMERGENCY CONTACT NAME		PHONE	RELATIONSHIP

INSURANCE INFORMATION

If we are filing with your general health insurance, and you have provided a copy of your insurance card, you do not need to fill out the following section. However, if your injury was due to a motor vehicle accident or a worker's comp injury, the following section is required.		
INSURANCE COMPANY	PHONE NUMBER	
ADJUSTOR'S NAME	EXTENSION NUMBER	
BILLING ADDRESS	CITY	ZIP CODE
CLAIM NUMBER	DATE OF INURY	
PLACE OF ACCIDENT	IS THIS WORK RELATED	

I understand and agree (regardless of my insurance status) that I am ultimately responsible for the balance of my account for any professional services rendered. I am also responsible for recognizing insurance status including, but not limited to, benefits and allowable visits. I have read all the information on this page and certify that the information I have provided is true and correct to the best of my knowledge. I also agree to notify First Option Physical Therapy of any changes to the above information.

_______________________________________ ________________

SIGNATURE DATE

MEDICAL HISTORY

1. Who is your referring physician?____
2. What are you being seen for today? ____
    a. When was the onset of your symptoms and/or injury: ___/___/___
    b. How did your symptoms begin? ____
3. How often do you experience your symptoms?
    ☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)
    ☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)
4. What describes the nature of your symptoms?
    ☐ Sharp ☐ Dull Ache ☐ Numb ☐Shooting ☐ Burning ☐ Tingling
5. Have you fall?______ How many times?___________ When?__________________________
6. During the past four weeks:
    a. Indicate the average intensity of your symptoms:

None 0 1 2 3 4 5 6 7 8 9 10 Unbearable

    b. How much have your symptoms interfered with your normal daily activities?
        ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐Extremely
7. During the past four weeks, how much have your symptoms interfered with your social activities?
    ☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ Not at all
8. In general, would you say your overall health right now is:
    ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
9. Has a physician ever warned you against exercise: ☐ Yes ☐ No
    If yes, please explain: ____
10. Please list any medical conditions (esp. heart disease/implants, diabetes, BP & respiratory):
    ____
11. Please list (or attach a list of) any medications you are currently taking:
    ____
12. Have you ever been treated by a Physical Therapist for these symptoms: ☐ Yes ☐ No
    If yes, please explain: ____
13. Are you undergoing, or have you undergone any other treatment for these symptoms? ☐ No
    ☐ Yes, please explain: ____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

_______________________________ _____________
SIGNATURE DATE

CONSENT FOR TREATMENT

I hereby give my permission for First Option Physical Therapy to render treatment to me/my dependent. I understand that I will be given all available pertinent information prior to the treatment being rendered. I will be given the opportunity to ask questions and to have them answered to my satisfaction. I understand that I may decline treatment at any time.

______________________________ ______________

SIGNATURE DATE

CONSENT TO RELEASE/OBTAIN MEDICAL INFORMATION

Permission is hereby granted to First Option Physical Therapy to release information to my insurance company, employer, attorney, workers compensation carrier, physician/facility referred to for further treatment and/or my referring/family physician. Permission is hereby granted to any facility where I have been previously treated to release medical records to First Option Physical Therapy.

______________________________ ______________

SIGNATURE DATE

AUTHORIZATION FOR PAYMENT OF BENEFITS

I authorize First Option Physical Therapy to bill my health insurance for services rendered. All payments received will be applied to my balance. I will be responsible for all co-pays/co-insurance and deductibles that may apply. Although First Option Physical Therapy will help verify and assist me in understanding my benefits, it is ultimately my responsibility and I will not hold First Option Physical Therapy responsible for any misinterpretation of insurance benefits. I understand that any charges not paid by my insurance company are my responsibility, and are due and payable by me.

______________________________ ______________

SIGNATURE DATE

MEDICARE PATIENTS ONLY

I authorize payment of Medicare benefits to First Option Physical Therapy for services rendered. I also authorize the release of medical information to CMS (Centers for Medicare and Medicaid Services) and/or its agents. I have read and understand the CMS limits on physical therapy benefits.

______________________________ ______________

SIGNATURE DATE