ADVANCED PHYSICAL THERAPY | PREFERRED PHYSICAL THERAPY

A MEMBER OF THE CONFLUENT HEALTH FAMILY

Patient Registration Form – Commercial Insurance

Patient Name: Preferred:	
Address, City, State, Zip:	
DOB: Social Security #:	
Email Address:	
Home Phone:	Appointment Reminder Method
Cell Phone:	☐ Home Phone ☐ Cell Phone
Work Phone:	☐ Work Phone ☐ Email

Marital Status: ☐Single ☐ Married ☐Divorced ☐Widowed Partner's Name:

Financial Responsibility: ☐Self ☐Other, Please List:

Emergency Contact Name/Address:

Emergency Contact Phone: Relation:

General Physician: Referred By:

Have you had Physical Therapy treatment since January of this year? ☐Yes ☐No If yes, # of Visits:

Have you had Chiropractic treatment since January of this year? ☐ Yes ☐No If yes, # of Visits:

Have you had Home Healthcare in the last 30 days? ☐ Yes ☐ No If yes, Home Healthcare Provider:

INSURANCE INFORMATION- Please Note: A copy of your insurance card(s) will be kept on file. The patient is responsible to provide their most current insurance information.

Primary Insurance:		Secondary Insurance:	
Group #:	Policy #:	Group #:	Policy #:
Insured Information:		Insured Information:	
Spouse			

Consent to Treat/Assignment of Benefits/Acknowledgements

I hereby authorize and consent to treatment/services for myself, or on the behalf of the above-named patient performed by the staff at Advanced PT, LLC and/or as directed by my referring provider. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including risk or alternatives to the recommended treatment plan.

I assign payment for these services directly to Advanced PT, LLC. I authorize the filing of claims to my insurance plan and authorize Advanced PT, LLC to release necessary health information related to these services to process the claims. I certify that the information I have provided is accurate and complete.

In signing this form, I will promptly pay any required co-pay, coinsurance and/or deductible amounts. I accept that insurance plans may deny payments for what I believed were covered services, resulting in my responsibility for paying for these services.

I acknowledge that I have received the Notice of Privacy Practices, which describes the ways the practice may use or disclose my healthcare information. I understand that my healthcare information may be used for treatment, payment, healthcare operations and other permitted uses or disclosures as described in the Notice.

_____ _____

Signature of Patient/Guardian Date

_____

Print Name and Relationship to the Patient

Patient name:

Authorization for Communication

By providing my above contact information and signing below, I consent and authorize Advanced PT, LLC and its related entities, agents, contractors, including but not limited to scheduling, billing, marketing and other departments to use automated telephone dialing systems, SMS text messaging, and electronic mail to (1) provide messages (including prerecorded messages or text messages) to me about appointment reminders, patient surveys, my account, payment due dates, missed payments, information for or related to medical goods and/or therapy services provided, exchange information, changes to health care law, health care coverage, care follow-up, and other healthcare information or (2) provide messages (including pre-recorded messages) during a call or via text message that delivers a 'health care' message made by, or on behalf of, a 'covered entity' or its 'business associate' as those terms are defined in the HIPAA Privacy Rule, 45 CFR 160.103. I understand that providing a telephone number and/or email address is not a condition of receiving medical services.

I also understand that I may revoke my consent to contact at any time by directly contacting <Company Name> or using the opt-out method that will be identified in the applicable communication. I also understand that it is my responsibility to notify Advanced PT, LLC immediately of any change in telephone number or email address.

Patient/Guardian Signature: Date:

Release of Information

I hereby authorized Advanced PT, LLC to discuss my personal healthcare information regarding my treatment including diagnosis/prognosis and/or billing and payment for services rendered on my behalf to the person(s) listed below.

_____	_____	_____
Name (print)	Relationship	Phone number
_____	_____	_____
Name (print)	Relationship	Phone number
_____	_____	_____
Name (print)	Relationship	Phone number

Patient/Guardian Signature: Date:

Financial Policy

Payment for services is due at the time services are rendered

We will verify your benefits with your insurance carrier. However, this does not guarantee that they will cover the prescribed treatment. By signing below, you are acknowledging that you are responsible for deductibles, copays, coinsurance, and non-covered services not paid by the insurance carrier and understand that you are fully responsible for any balance due for services rendered.

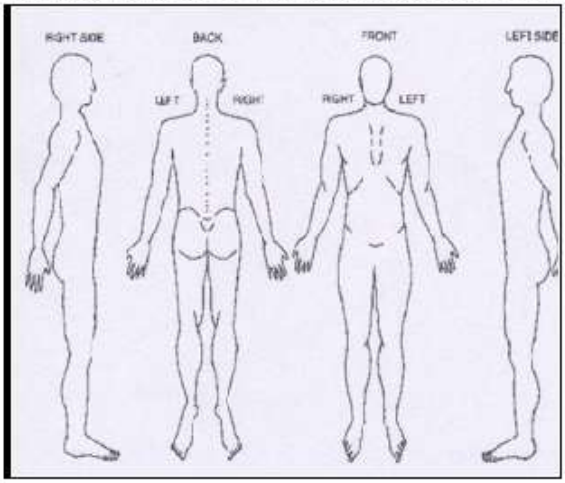
Patient/Guardian Signature: Date:

PATIENT HEALTH QUESTIONNAIRE
Patient Name: **Name You Go By:**
What are your pronouns? ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other:
Do you think of yourself as: ☐ Male ☐ Female ☐ Transgender ☐ Neither exclusively male nor female ☐ Additional gender category, please specify: ☐ Decline to Answer
What sex was originally listed on your birth certificate? ☐ Male ☐ Female ☐ Decline to Answer For billing purposes, it is helpful to know gender assigned at birth. There can be confusion when a patient legally changes their birth certificate to the gender they align with, but insurance companies' data is lagging behind.
Occupation: Height: Weight:
Leisure Activities/Hobbies:
Are you? ☐ Right-handed ☐ Left-handed
Where do you live? □ Private Home □ Apartment/Rented Room □ Assisted Living/Group Home □ Hospice □ Other:
With whom do you live? □ Alone □ Spouse Only □ Spouse and Others □ Child □ Other:
Does your home have? □ Stairs, No Railing □ Stairs, Railing □ Ramps □ Uneven Terrain Please Explain:
How many times have you fallen in the past 12 months? Did it result in an injury? ☐ Yes ☐ No
During the past month have you been feeling down, depressed, or hopeless or bothered by having little interest or pleasure in doing things? ☐ Yes ☐No
General Health Status: Please rate your health. □ Excellent □ Good □ Fair □ Poor
Please list any known allergies (including medications, latex, etc.) here.

Current Condition
When did this problem(s) first begin/date of onset? If chronic, when did you seek medical treatment?
Is your current condition related to recent surgery? ☐ Yes ☐ No If yes, specify date of surgery:
Describe the problem(s).
Explain how problem(s) occurred.
Have you ever had this problem before? ☐ Yes ☐ No If yes, how many times?
Are your symptoms worse in the: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Same All Day
How are you taking care of the problem(s) now?
My pain/problem is slowing getting: ☐ Worse ☐ Better ☐ Staying the Same
My symptoms bother me: ☐ Constantly (100%) ☐Most of the Time (75%) ☐ Occasionally (50%) ☐ Once in a While (25%)
Do you have any numbness, tingling, or burning? ☐ Yes ☐ No If yes, please check one: ☐ Constantly ☐ Intermittently
What functions could you perform before, that you now are unable to do?
Please explain any specific treatment you have received for this problem, such as previous physical or occupational therapy, chiropractic visits, pain medications, etc.
Have you received X-rays, MRI, CT scan, Bone scan for this problem? If so, please list the dates and results.
Are you aware of any physical reason why you should not receive treatment? ☐ Yes ☐ No If yes, please tell us what it is:
What are your goals for therapy?

Patient Name:	
Surgery / Hospitalization, please include date and reason.	

Indicate where you have pain/symptoms on the body charts with an X:



Rate your pain from 0-10 (0=no pain, 10=excruciating) for the following:

Worst it has been: _____ Best it has been: _____

At this moment: _____

Indicate the nature of your pain and symptoms (circle all that apply):

Sharp Aching Shooting Dull Tingling Burning Numb

Is the pain constant? _____ Or does it come and go? _____

Please list current medications (including prescription, over the counter, and herbal). You can also provide our office staff a list to copy.

Name	Dosage	Frequency	Please Indicate Route
			Oral Patch Topical Other
			Oral Patch Topical Other
			Oral Patch Topical Other
			Oral Patch Topical Other

Are you currently experiencing any of the following?			
Nausea or Vomiting	☐ Yes ☐ No	Chest Pains (Angina)	☐ Yes ☐ No
Productive/Chronic Cough	☐ Yes ☐ No	Pain Wakes Me at Night	☐ Yes ☐ No
Difficulty Swallowing	☐ Yes ☐ No	Recent Fever, Chills, Sweats	☐ Yes ☐ No
Dizzy Spells	☐ Yes ☐ No	Difficulty Sleeping	☐ Yes ☐ No
Headaches	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Visual Problems	☐ Yes ☐ No	Heart Palpitations	☐ Yes ☐ No
Hearing Loss/Ringing in Ears	☐ Yes ☐ No	Loss of Appetite	☐ Yes ☐ No
Difficulty Walking	☐ Yes ☐ No	Incontinence	☐ Yes ☐ No
Unusual Weakness	☐ Yes ☐ No	Fatigue or Myalgia	☐ Yes ☐ No
Joint Pain or Swelling	☐ Yes ☐ No	Unexplained Weight Changes	☐ Yes ☐ No

Social History / Wellness	
Do you drink alcoholic beverages? ☐ Yes ☐ No	Do you use tobacco? ☐ Yes ☐ No
How often have you completed at least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your condition? ☐ At least 3 times per week ☐ 1-2 times per week ☐ Seldom or Never	

Patient Name:			
Have you been diagnosed with any of the following?			
Allergies	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	HIV	☐ Yes ☐ No
Hepatitis, If Yes, Type:	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Respiratory Problems	☐ Yes ☐ No	Kidney Disease/Problems	☐ Yes ☐ No
Auto Immune Disease If yes, Type:	☐ Yes ☐ No	Spinal Cord Stimulator	☐ Yes ☐ No
Blood Clots	☐ Yes ☐ No	Vision Problems	☐ Yes ☐ No
Bowel or Bladder Disorder	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Cancer, If yes, Site:	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Cardiac Conditions	☐ Yes ☐ No	Parkinson's	☐ Yes ☐ No
Cardiac Pacemaker	☐ Yes ☐ No	Peripheral Vascular Disease	☐ Yes ☐ No
Currently Pregnant	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Speech Problems	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Hearing Loss	☐ Yes ☐ No
Stroke/TIA	☐ Yes ☐ No	Fractures	☐ Yes ☐ No

I will advise the therapist if there is any change in my physical condition which will alter my response to any of the questions on this form.

Signature: _____ Date: _____