

**Patient Registration Form – Commercial Insurance**

Patient Name:		Preferred:	
Address, City, State, Zip:			
DOB:		Social Security #:	
Email Address:			
Home Phone:		Appointment Reminder Method	
Cell Phone:		<input type="checkbox"/> Home Phone	<input type="checkbox"/> Cell Phone
Work Phone:		<input type="checkbox"/> Work Phone	<input type="checkbox"/> Email
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Partner's Name:	
Financial Responsibility: <input type="checkbox"/> Self <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, # of Visits:			
Have you had Chiropractic treatment since January of this year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, # of Visits:			
Have you had Home Healthcare in the last 30 days? <input type="checkbox"/> Yes <input type="checkbox"/> 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:	

**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**

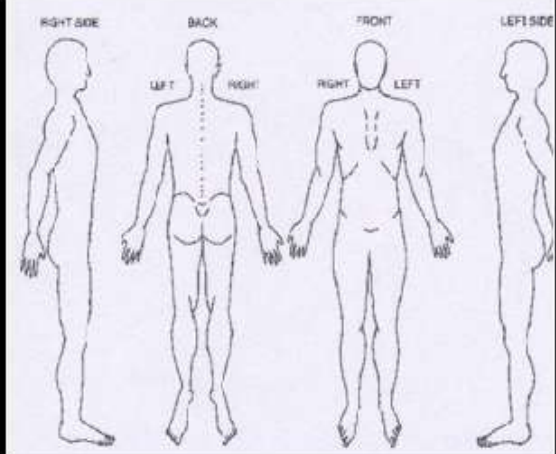
<b>Patient Name:</b>	<b>Name You Go By:</b>	
Occupation:	Height:	Weight:
Leisure Activities/Hobbies:		
Are you? <input type="checkbox"/> Right-handed <input type="checkbox"/> Left-handed		
Where do you live? <input type="checkbox"/> Private Home <input type="checkbox"/> Apartment/Rented Room <input type="checkbox"/> Assisted Living/Group Home <input type="checkbox"/> Hospice <input type="checkbox"/> Other:		
With whom do you live? <input type="checkbox"/> Alone <input type="checkbox"/> Spouse Only <input type="checkbox"/> Spouse and Others <input type="checkbox"/> Child <input type="checkbox"/> Other:		
Does your home have? <input type="checkbox"/> Stairs, No Railing <input type="checkbox"/> Stairs, Railing <input type="checkbox"/> Ramps <input type="checkbox"/> Uneven Terrain Please Explain:		
How many times have you fallen in the past 12 months?		Did it result in an injury? <input type="checkbox"/> Yes <input type="checkbox"/> No
During the past month have you been feeling down, depressed, or hopeless or bothered by having little interest or pleasure in doing things? <input type="checkbox"/> Yes <input type="checkbox"/> No		
General Health Status: Please rate your health. <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		
Please list any known allergies (including medications, latex, etc.) here.		

<b>Current Condition</b>
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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify date of surgery:
Describe the problem(s).
Explain how problem(s) occurred.
Have you ever had this problem before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many times?
Are your symptoms worse in the: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night <input type="checkbox"/> Same All Day
How are you taking care of the problem(s) now?
My pain/problem is slowing getting: <input type="checkbox"/> Worse <input type="checkbox"/> Better <input type="checkbox"/> Staying the Same
My symptoms bother me: <input type="checkbox"/> Constantly (100%) <input type="checkbox"/> Most of the Time (75%) <input type="checkbox"/> Occasionally (50%) <input type="checkbox"/> Once in a While (25%)
Do you have any numbness, tingling, or burning? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please check one: <input type="checkbox"/> Constantly <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please tell us what it is:
What are your goals for therapy?

<b>Surgery / Hospitalization, please include date and reason.</b>

**Patient Name:** \_\_\_\_\_

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

	<p><b>Rate your pain from 0-10 (0=no pain, 10=excruciating) for the following:</b></p> <p>Worst it has been: _____ Best it has been: _____</p> <p>At this moment: _____</p>
	<p><b>Indicate the nature of your pain and symptoms (circle all that apply):</b></p> <p>Sharp    Aching    Shooting    Dull    Tingling    Burning</p> <p>Numb</p>
	<p><b>Is the pain constant?</b> _____ <b>Or does it come and go?</b> _____</p>

**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	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest Pains (Angina)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Productive/Chronic Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain Wakes Me at Night	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty Swallowing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Fever, Chills, Sweats	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizzy Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty Sleeping	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Visual Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Palpitations	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing Loss/Ringing in Ears	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of Appetite	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty Walking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No
Unusual Weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fatigue or Myalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Joint Pain or Swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unexplained Weight Changes	<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis, If Yes, Type:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Respiratory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease/Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Auto Immune Disease If yes, Type:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spinal Cord Stimulator	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Clots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bowel or Bladder Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer, If yes, Site:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Peripheral Vascular Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Currently Pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Speech Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke/TIA	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> 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: \_\_\_\_\_