



Patient Registration Form

**Personal Information**

Name:		Name you prefer:	
Home Address:		Apt #	
City:	State:	Zip Code:	
Mailing Address:			
City:	State:	Zip Code:	
Injury/ Diagnosis:		Home Phone:	
Date of Injury/Onset of symptoms:		Work Phone:	
Date of Birth:	Age:	Cell Phone:	
Email Address:			
Emergency Contact:		Emergency Contact Phone #:	
How did you hear about us?:			

Referring Physician Name:		Phone #:	
City, State:			
Primary Care Physician Name:		Phone #:	
City, State:			
Employer Name:		Occupation:	
Address:		City, State:	
Social Security Number (For Insurance Benefit Verification):			

**Primary Insurance Information**

Is this an auto accident?:	Yes	No	Is this a worker's comp case?:	Yes	No
If "Yes", list claim # and adjuster contact information:					
Health Insurance Company Name:					
Subscriber's Name:			Subscriber's Date of Birth:		
Relationship to the Subscriber:					
Subscriber's Address and Phone # if different from patient:					
Address:					
City, State		Zip		Phone#	

## Secondary Health Insurance Information

Health Insurance Company Name:		
Subscriber's Name:	Subscriber's Date of Birth:	
Relationship to the Subscriber:		
Subscriber's Address and Phone # if different from patient:		
Address:		
City, State	Zip	Phone#

## Consent to Treatment

I hereby authorize the professional staff at Proex Physical Therapy to examine and treat me with physical therapy for the injury I have been referred here for or referred myself to.

_____	_____
Patient Signature	Date
_____	
Patient Printed Name	
_____	_____
Parent or Guardian Signature (if under 18)	Date
_____	_____
Parent or Guardian Printed Name	Staff Witness Signature

## ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO HEALTH PROVIDER

Insurance Company/Companies Name(s) \_\_\_\_\_

I hereby instruct the above named insurance company/companies to pay by check made out to and mailed directly to: **ProEx Physical Therapy** for professional/medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for services rendered.

### **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.**

This payment will not exceed my indebtedness to the above mentioned assignee and I agree to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment as required by my insurance policy. I understand that **ProEx Physical Therapy** is compliant with HIPAA will protect my *Protected Health Information (PHI)* and will use it as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed and full payment is received. I also authorize the release of any information pertinent to my case to any insurance, adjuster or attorney for the purpose of securing payment under this insurance policy or to any medical provider associated with my case to effectively treat me, following HIPAA guidelines. The authorization is in effect until 90 days from the date the last bill is collected. A photocopy of this Assignment shall be considered effective and valid as the original.

If there is anyone you would like authorize the disclosure of your Protected Health Information, medical or billing, you may specifically name the party below and initial next to what information you would like to disclose: \_\_\_\_\_

Info related to diagnosis and physical therapy treatment ONLY \_\_\_\_\_

Medical Billing Info ONLY \_\_\_\_\_

My entire medical record \_\_\_\_\_

\_\_\_\_\_ Date

Patient Name (Printed)

\_\_\_\_\_ Patient Signature

\_\_\_\_\_ Relationship

Parent or Guardian (Printed)

\_\_\_\_\_ Parent or Guardian Signature

\_\_\_\_\_ Staff Witness Signature

\_\_\_\_\_ Date



# Physical Therapy

## Medical History Information Sheet

1. What would you say is the pain rating for your current condition using a scale of 0 – 10? (0=no pain, 10=worst pain imaginable) \_\_\_\_\_

2. Do you now or have you ever had the following?		Explain
<i>Stroke</i>	yes _____ no _____	_____
<i>Heart Disease or Heart Murmur</i>	yes _____ no _____	_____
<i>High Blood Pressure</i>	yes _____ no _____	_____
<i>Asthma</i>	yes _____ no _____	_____
<i>Diabetes</i>	yes _____ no _____	_____
<i>Epilepsy/Fainting</i>	yes _____ no _____	_____
<i>Impairment of Vision or Hearing</i>	yes _____ no _____	_____
<i>Cancer</i>	yes _____ no _____	_____
<i>Drug Allergies</i>	yes _____ no _____	_____
<i>Osteoporosis</i>	yes _____ no _____	_____

### **Orthopaedic History – Please give dates & treatments received:**

3. Have you ever sprained, strained, dislocated or fractured the following:

Neck/Head (including concussion) \_\_\_\_\_

Trunk (ribs, vertebrae, sternum) \_\_\_\_\_

Low Back (vertebrae, discs, nerves) \_\_\_\_\_

Upper Extremity (shoulder, elbow, wrist, arm) \_\_\_\_\_

Lower Extremity (hip, leg, knee, ankle, foot) \_\_\_\_\_

4. Please list any surgeries that you have had and their dates:

\_\_\_\_\_

5. Please list medication(s) presently taking: \_\_\_\_\_

6. Women: Are you pregnant? yes \_\_\_\_\_ no \_\_\_\_\_

7. Have you ever had PT in the past? \_\_\_\_\_  
If so, when? \_\_\_\_\_

8. **IF YOU HAVE MEDICARE, HAVE YOU EVER HAD HOME HEALTH CARE?** \_\_\_\_\_

9. If so, what is the **name and phone number** to the agency? \_\_\_\_\_

I agree that the above information accurately describes my medical history and that should any changes in my medical history occur, I will notify my PT immediately

Signature \_\_\_\_\_ date: \_\_\_\_\_



## **Missed Appointment Policy**

We strive to provide our patients with excellent service and quality care. Our commitment to your well-being and health care is something that we at *PROEX Physical Therapy* take very seriously.

Your commitment to your physical therapy program is critical to your success. We will recommend treatment and set goals for you. In order to reach those goals you must do your part and your most important part is to make each and every appointment.

We will give you an appointment card to keep track of your appointments. If you should misplace this, please give us a call to review your appointment dates. We expect you to keep all your appointments, however should you need to cancel please note that we require a **24-hour notice**.

If you need to cancel please call our office and reschedule. If you do not cancel with a **24-hour notice** or if you do not show for an appointment **you will be charged \$20** for the missed appointment.

If you miss **3** consecutive appointments we will notify your physician and will require a new referral in order to continue your treatment.

We thank you for choosing *PROEX Physical Therapy* and we are looking forward to working with you and helping you reach your goals.

*The Staff at PROEX Physical Therapy*

**I have read and understand this policy.**

\_\_\_\_\_  
Patient/ Guardian

\_\_\_\_\_  
Date