PATIENT REGISTRATION

PATIENT INFORMATION (Please Print)

Last:_____ First:_____ Middle Initial:____ Chosen Name:_____

Date of Birth:_____ Social Security Number (Optional): XXX-XX- _____ Age: _____

Address:_____ Apartment:_____

City:_____ State:_____ Zip Code:_____ County:_____

Primary Phone:_____ ☐Home ☐Mobile ☐Work ☐Other: _____

Secondary Phone:_____ ☐Home ☐Mobile ☐Work ☐Other: _____

Email:_____Would you like to receive appointment reminders? ☐Email ☐Text ☐Opt-Out

Preferred Language:_____ Do you require an interpreter? ☐Yes ☐No

Relationship Status: ☐Single ☐Married ☐Civil Union ☐Life Partner ☐Divorced ☐Widowed

Height (Optional): _____ Weight (Optional): _____

Gender Identity:_____ Pronouns:_____

What sex were you assigned at birth? ☐Male ☐Female ☐Intersex ☐Decline to Answer

Do you have any privacy concerns? ☐Yes ☐No *If yes please discuss your concerns with your provider.*

Employer/School:_____ Occupation: _____

Employment Status: Employed: ☐Full-Time / ☐Part-Time ☐Self Employed ☐Child ☐Active-Duty Military

Student: ☐Full-Time / ☐Part-Time ☐Unemployed ☐Disabled ☐ Retired (date):_____

Emergency Contact Information

Emergency Contact Name:_____ Phone:_____ Relationship:_____
Emergency Contact Name:_____ Phone:_____ Relationship:_____

RESPONSIBLE PARTY (GUARANTOR INFORMATION)

Relationship to Patient ☐Self (*if self, skip to Insurance Information*) ☐Parent/Guardian ☐Spouse ☐Other

Last Name:_____ First Name:_____ Middle Initial:_____

Date of Birth:_____ Social Security Number (Optional): XXX-XX- _____

Address:_____ Apt:_____

City: _____ State:_____ Zip:_____

Primary Phone:_____☐Home ☐Mobile ☐Work ☐Other:_____

PRIMARY INSURANCE INFORMATION (REQUIRED)

Insurance Company:_____ Phone: _____

Subscribers Name:_____ SSN (Optional): XXX-XX- _____ Date of Birth:_____

Policy ID Number:_____ Group Number:_____

Relationship to Patient: ☐Self ☐Mother ☐Father ☐Spouse ☐Other (please specify):_____

SECONDARY INSURANCE INFORMATION (REQUIRED if you have a secondary plan)

Insurance Company:_____ Phone: _____

Subscribers Name:_____ SSN (Optional): XXX-XX-_____ Date of Birth:_____

Policy ID Number:_____ Group Number:_____

Relationship to Patient: ☐Self ☐Mother ☐Father ☐Spouse ☐Other (please specify):_____

CURRENT INJURY / SYMPTOM INFORMATION

Referring Provider:_____Date of injury (if applicable): _____

What is your injury or concern? _____

Do you have any accessibility needs?_____ Do you feel safe in your home? ☐Yes ☐No

What is the nature of your current injury?

☐Recreational ☐ Chronic/Recurring ☐Fall ☐Insidious ☐Surgery ☐Other _____

☐Work Related – Injury Date: _____ ☐ Auto Accident – Injury Date: _____

Have you had surgery for this injury/symptom? ☐Yes ☐No Date and type of surgery:_____

Are you currently receiving, or have you received Home Health Care within the past 60 days? ☐Yes ☐No

If yes, where? _____ Have you been discharged? ☐Yes ☐No Discharge Date: _____

Have you received Physical (PT), Occupational (OT), or Speech Therapy (SLP) within this calendar year? ☐Yes ☐No

If yes, what type of therapy?_____ Where was the treatment?_____☐Inpatient ☐Outpatient

PATIENT MEDICAL HISTORY

What is your goal for therapy? _____

How often do you exercise more than 20 minutes per day? ☐N/A ☐1-2x/week ☐3-4x/week ☐5-6x/week ☐Every Day

Do you smoke? ☐Yes, _____packs per day. ☐No Are you pregnant? ☐Yes ☐No

List any recent diagnostic testing you have had for this injury (X-Ray, MRI, CT scan, EMG, Injections, etc.):_____

_____

Do you have any allergies to latex, cold, or heat? ☐Yes ☐No If yes, please specify:_____

Have you fallen in the last year?☐Yes ☐No If yes, how many times?_____

PAST MEDICAL HISTORY

Have you recently noted any of the following? (check all that apply)

☐ Fatigue	☐ Nausea/Vomiting	☐ Unexpected Weight Gain/Loss	☐ Numbness/Tingling
☐ Constipation	☐ Fever/Sweats/Chills	☐ Pain that keeps you awake	☐ Changes in Appetite
☐ Visual Changes	☐ Difficulty Swallowing	☐ Rapid Heart Rate/Palpitations	☐ Changes in Bowel or Bladder
☐ Incontinence	☐ Dizziness/Lightheaded	☐ Recent onset of Headaches	☐ Unexplained Cough
☐ Fainting	☐ Muscle Weakness	☐ Shortness of Breath	☐ Urinary Tract Infection

☐ Prior Surgeries, please describe:_____

Have you ever been diagnosed with the following? (check all that apply)

☐ Anemia	☐ Bone/Joint Infections	☐ High/Low Blood Pressure	☐ Back Pain (Degenerative, Stenosis, Herniation)
☐ Asthma/Allergies	☐ Seizures or Epilepsy	☐ Lung Disease/COPD/ARDS	☐ GI Disease (Liver, Ulcer, Hernia, Reflex, Gallbladder)
☐ Pneumonia	☐ Diabetes Type 1 or 2	☐ Bladder/Urinary/Kidney Disease	☐ Vascular/Circulation Problems/Blood Clots
☐ Cancer (any)	☐ Chronic Headaches	☐ Osteoarthritis/Rheumatoid Arthritis	☐ Depression/Anxiety/ Panic Disorders
☐ Stroke/CVA/TIA	☐ TB/HIV/Hepatitis A/B/C	☐ Congestive Heart Failure/Heart Attack	☐ Neurological Disease (MS, Parkinson's)
☐ Thyroid Condition	☐ Chest Pain or Angina	☐ Visual or Hearing Impairments	☐ Other(s)

MEDICATION LISTING

Welcome to PT Solutions Physical Therapy. Whether you are seeing your PCP or your physical therapist, providing a list of your medications with the name, dosage and frequency helps to provide you with the best care possible. Medications can affect your heart rate and blood pressure, and may even cause dizziness, muscle soreness and fatigue, among other side effects. Participation in therapy may cause these same symptoms. Knowing what medications, you are taking helps the therapist design the best program for you.

Patients Name: _____ **Date of Birth:** _____

Please list the name, dose, how often, reason, and the last dose of each medication in the table below

Information provided by: ☐Patient ☐Family ☐Written List Attached ☐Other _____

Medication (include strength)		Dose	Frequency	Reason	Last Dose
Example:	Aspirin	325 mg	Daily	Heart	*i.e. date discontinued or added*
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

APPOINTMENT AND CANCELLATION POLICY

Cancellation of an Appointment

Our goal is to provide quality rehab care in a timely manner. In order to be respectful of the rehab needs of all PT Solutions patients, **please be courteous and call our office promptly if you are unable to attend an appointment.** This time will be reallocated to someone who is in need of treatment.

Appointments are in high demand, and your early cancellation will give another patient the opportunity to have access to timely medical care.

PT Solutions reserves the right to charge a cancellation fee $ _____ of if your appointment is not canceled at least ___24____ hours prior to your scheduled appointment.

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

If you would like the details of your (or the patients, as identified on the first page of this form) treatment, test/lab results, and/or payment information, to be communicated to anyone other than you, the patient/guarantor, please complete the information below identifying such person.

This is not a release for your Medical Records*. To obtain copies of your medical records, please complete the HIPAA Authorization to Release Protected Health Information and submit the form to our Medical Records department for processing. Medical records cannot be released by the clinic where you are receiving treatment. Please allow up to thirty*
(30) days for processing.

Patient's Name:_____ Date of Birth:_____

Address:_____Phone Number: _____

City:_____ State:_____ Zip Code:_____

I hereby authorize:
Custodian Information

To disclose to:_____

Name of individual(s) to whom disclosure is to be made

_____

Address, City, State, Zip

Specific Information to be disclosed:_____

Reason for Disclosure:_____

Date of Treatment:_____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the caregivers listed above. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: **discharge or end of current visit.**
I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I many inspect the information to be used or disclosed, as provided in C.F.R 154.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient and that the re-disclosed information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Privacy Officer at 678-402-2002. PT Solutions is not responsible for any re-disclosure of the information provided.

I further acknowledge that the information to be released was fully explained to me and this authorization is given of my own free will.

Executed this, the _____ day of _____ , 20_____.

Signature of Patient:_____ Date:_____

Time:_____ am / pm

GENERAL CONSENT FOR TREATMENT & CONTACT, ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY, & RELEASE

1. **General Consent for Treatment**. I voluntarily consent to and authorize such care and treatment, included but not limited to physical examinations, diagnostic testing, medical procedures and medications by employees and authorized agents of PT Solutions, as may be considered necessary or advisable in their professional judgement. I understand that PT Solutions may provide certain services by remote telemedicine technology. Such telemedicine services involve a healthcare provider who is at a site remote from my location at the time of the service, and may require the transmission of video, audio, images, or other types of electronic data about by condition. The types of activities permitted using telemedicine services include consultation, therapeutic diagnosis, treatment, and patient education. The remote healthcare provider will determine whether the condition being treated is appropriate for telemedicine. I give consent for my treating therapist at PT Solutions to exchange information with other remote health care providers to facilitate the provision of telemedicine services. I understand that PT Solutions uses security measures such as encryption and authentication techniques to protect electronic information stored or transmitted during telemedicine services, but that there may be potential risks to privacy notwithstanding such measures. I agree to hold PT Solutions harmless for information lost due to technical failures. Lastly, I acknowledge that no guarantees have been made regarding the effect of any care or treatment, whether in-person or using telemedicine technology, on any medical condition.
2. **Assignment of Benefits/Financial Responsibility.** I Authorize and Assign all claims for payment of any insurance or third parties directly to PT Solutions or its agents for services rendered. I agree, in consideration of services rendered by PT Solutions and its agents, to be responsible for payment in full including any collection fees in the event payment is not made in full.
3. **Release of Information.** I hereby authorize and direct PT Solutions and or its representatives having treated me, to release to government agencies, insurance carriers, or others who are financially liable, any or part of my medical record for my medical care.
4. **Other Consents.** I understand that PT Solutions participates in an affiliated teaching program. As part of the program, therapists may be assisted in patient care by therapy students. I understand I have the right to refuse therapy students be involved in my care and will notify my provider(s) of any such decision.
5. **Notice of Privacy Practices.** I acknowledge that I have received or declined PT Solutions Notice of Privacy Practices. I further acknowledge for myself (or on behalf of the patient in my capacity as authorized representative of the patient identified on the first page of this form), that I have been made aware of PT Solutions' legal duties, policies, and procedures, regarding the protection of my (or the patient's) personal health information and that I have received a copy of PT Solutions' notice of privacy practices describing these policies and protections, and further acknowledge that a copy of PT Solutions' notice of privacy practices is available on the PT Solutions website. I understand and agree that, unless I request otherwise in writing, PT Solutions will communicate with me via phone, fax, text message, and/or email, and will state the company name (PT Solutions) when leaving messages for me (or the patient) via any of these means.
   PT Solutions will never communicate or otherwise provide medical advice via answering machine, voicemail, text messages with family members, email, text, or fax.
6. **Authorization for Receiving Messages and Automated Calls.** I give PT Solutions (including its agents and third-party collection agents) permission to contact me by telephone at the telephone numbers or number I provided during the registration process, or at any time in the future, including wireless telephone numbers or other numbers that may result in charges to me. PT Solutions and its agents may leave messages for me at these numbers and may send text messages or email communications using the email address or addresses I provide. These voice messages and email and text communications may include information required by law (including debt collection laws) related to amounts I owe PT Solutions as well as messages related to my continued care and treatment.
   I also understand that PT Solutions and its agents, including debt collection agencies, may use pre-recorded/artificial voice messages and/or use an automatic dialing devise (an auto dialer) to deliver messages related to my account and amounts I may owe PT Solutions. I also authorize PT Solutions and its agents to use the number or numbers provided for such pre-recorded or auto dial messages. If I want to limit these communications to a specific telephone number or numbers, I understand that I must request that only one designated number or numbers be used for these purposes. I understand my agreement is not a requirement to receive medical care.
   I acknowledge and understand that I may contact PT Solutions' Compliance Director should I have questions or comments regarding PT Solutions' privacy practices at **678-402-2002 / compliance@ptsolutions.com**.
   I hereby certify that the medical history provided is true and accurate to the best of my knowledge. I further acknowledge that I have read and understand the consents, authorizations, and policies as described above.

Patient/Guardian Signature

Date / Time