PISGAH PHYSICAL THERAPY: PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient First Name: MI: Last Name:	Age:	Date of Birth:	Gender: ☐ Male ☐ Female

Ethnicity? ☐ Hispanic ☐ Not Hispanic ☐ Refused Marital Status? ☐ Single ☐ Married ☐ Widowed/Divorced	Language Spoken? ☐English ☐ Spanish ☐Other Race? ☐ White ☐ Asian ☐ Black ☐Hispanic ☐ Indian/Native ☐Other

Mailing address:	Social Security #(*Required):

City:	State:	Zip Code:	Home Phone: Cell Phone: Work Phone:

Email Address: ☐I do not have access to email	Driver License#:

Is the patient covered by insurance? ☐ Yes ☐ No Pharmacy_____

INSURANCE INFORMATION(*Please fill out ONLY if patient is on spouse or parent's insurance plan)

(Please give insurance card to the receptionist to be scanned. We are NOT responsible for filing claims if no card is on file)

PRIMARY INSURANCE ☐Medicare ☐ NC Medicaid ☐ BCBS ☐Other	Policy #:

Name on the insurance card? :	SS # of the policy holder(required):	Birth date of Policy Holder(required):	Group #:

How is the **patient** related to the policy holder? : ☐ Self ☐ Child (covered under parent's insurance) ☐Spouse ☐ Other

SECONDARY INSURANCE ☐None	Policy Holder: ☐Same as primary	Date of Birth	Policy #:

Patient's relationship to subscriber: ☐Self ☐ Child(covered under parent's insurance) ☐ Spouse ☐ Other

PARENT/GAURADIAN (REQUIRED IF PATIENT IS UNDER 21 YEARS) NOTE: Both Parents can be held responsible for medical bills for minors, a medical practice is **NOT** bound by any separation agreement, divorce or child support order.

Parent/Guardian:	**Birth Date:**	Address (if different): ☐ Same as above

Social Security #(required):	Employer:	Preferred Phone #:

IN CASE OF EMERGENCY WHO WOULD YOU LIKE TO BE CONTACTED?

Contact Name:	Relationship to patient:	Home phone #: ( )	Work phone #: ( )

By signing, you agree the information above is correct and give permission for Pisgah PT and Sports Rehab to file claims on your behalf.
HIPAA CONSENT: *Without signed consent, we can NOT share information regarding your medical care (including family). Please list anyone you would like to have this information below.* ☐ *I do not wish anyone to have information regarding my care.*

1. _____

2. _____

X_____ ***Date:***_____
Patient/Guardian Signature

Financial Policy and Signature on File
I authorize the release of any medical pertinent information to my consulting provider, if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of benefits to Pisgah Pisgah Physical Therapy and Sports Rehabilitation.

I understand that I am financially responsible for all services rendered **including** for the following reasons: 1) no proper referral at the time of service or referral is invalid/expired 2) incorrect/invalid insurance information given or failure to give any or new updated insurance information 3) Expenses not covered by insurance including labs 4) deductible not met 5) services rendered deemed medically unnecessary by insurance or non-covered/excluded services by your plan 6)not in network with your plan.
Failure of insurance company to pay does not excuse patient's financial responsibility. It is patient's responsibility to know what is and is not covered by their insurance policy/plan (including Medicare beneficiaries). Your contract is between you and your insurance carrier. YOU ARE RESPONSIBLE FOR VERIFYING NETWORK STATUS DIRECTLY WITH YOUR INSURANCE CARRIER.

Payment is required for all services at the time they are rendered including co-payments and any outstanding balances. You may be balance billed per your insurance contract guidelines for any amount not collected or known at the time of service. Outstanding balances not addressed/paid in a timely fashion may be forwarded to collections reported to your credit.
Returned Checks: In the event a check is returned for Non Sufficient Funds, we will assess a $25.00 charge in addition to your current balance to cover the bank charges incurred by our office due to Non Sufficient Funds.
Missed Appointments: We charge $50.00 for any no show appointment not cancelled within 24 hrs. This charge will be billed directly to you. Please help us to serve you better by keeping all scheduled appointments. If you "no show" to 3 appointments within 1 year, we have the right to dismiss you from our practice for non compliance.

Patient/Guardian Signature for Financial and Office Policies
(Refusal to sign does NOT prevent responsibility/obligation regarding this office's financial policy).

X_____ Date_____

HIPAA COMPLIANCE STATEMENT - *THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.*
At this practice, we are committed to protecting your privacy. We comply with all federal, state, and local laws. This notice describes how we use your health information. It describes some of your rights and some of our responsibilities.
UNDERSTANDING YOUR HEALTH RECORD/INFORMATION - Each time you visit our offices, we record your symptoms, physical examination, test results, diagnosis, and treatment. This information enables us to plan for your care, communicate with others who care for you, report to your insurance carrier, bill for our work, and improve the quality of our care to you.
YOUR RIGHTS - Although your medical chart belongs to our practice, the information contained in the chart is yours. You have the right to inspect your records, obtain a copy of your chart for a small fee, correct your records, and tell us not to release your information to certain parties.
OUR RESPONSIBILITIES - We are required to maintain the privacy of your health information, send needed health information to other medical providers, and release information to insurance companies, certain government agencies, and others. We may be required to release some information, even without your permission.
EXAMPLES OF HOW YOUR INFORMATION IS USED - Your health information will be recorded and used to plan your treatment. Reports may be sent to other doctors to help them plan your treatment. Claims will be sent to your insurance company. The information in the claims will include confidential information such as your name, address, diagnosis, and treatment. In providing your care, we may communicate with other individuals or businesses. Examples include other physicians and/or laboratories. To protect your privacy, we ask our business associates to safeguard your information.
OTHER NOTICES - We may leave a message at your home, at your business, on your answering machine or on your voicemail. We may mail you a postcard or other written notices. We may need to disclose your information to your family members or other people helping with your care. In doing so, we will use our best judgment. We may disclose information to others as required by law or if subpoenaed. If you were injured on the job, we will need to disclose your health information to your workers compensation insurance company. We may, from time to time, update these policies.
FOR MORE INFORMATION, QUESTIONS OR TO REPORT A PROBLEM - If you have concerns or would like additional information, you may contact the Office Manager.

Signature (HIPAA Policy)

X_____Date_____

PISGAH PHYSICAL THERAPY
PATIENT HISTORY

NAME: _____

Describe briefly the history of your present ACCIDENT, INJURY, and ILLNESS OR CONDITION:
Onset Date: _____ Description: _____

_____

_____

Please list any special concerns, questions or expectations:_____

_____

Have you fallen in the past year? _____ If so, how many times? _____ If so, did you sustain an injury?_____

Have you had any physical therapy during the current calendar year? _____ Have you had physical therapy for the same condition for which you are here today? _____ If yes, please indicate where and when:

_____

List **ALL** medications you are currently taking:_____

_____

Please list recent diagnostic studies (CAT scan, MRI, X-ray, ETC.) & where taken: _____

_____

Do you have METAL anywhere in your body (other than teeth), such as pins/plates, pacemaker, stints, etc.? Describe

_____

Please list **ALL** surgeries you have had; please give procedures and dates, if possible: _____

_____

_____

Have you ever had: (Please circle yes or no)

Allergies	Yes	No	Gallbladder	Yes	No
Anemia	Yes	No	Hepatitis	Yes	No
Anxiety	Yes	No	High Blood Pressure	Yes	No
Arthritis	Yes	No	Incontinence	Yes	No
Asthma	Yes	No	Kidney Problems	Yes	No
Cancer	Yes	No	Metal Implants	Yes	No
Cardiac Conditions	Yes	No	Multiple Sclerosis	Yes	No
Cardiac Pacemaker	Yes	No	Osteoporosis	Yes	No
Chemical Dependency	Yes	No	Parkinsons Disease	Yes	No
Circulation Problems	Yes	No	Rheumatoid Arthritis	Yes	No
Currently Pregnant	Yes	No	Seizures	Yes	No
Depression	Yes	No	Speech Problems	Yes	No
Diabetes	Yes	No	Strokes	Yes	No
Dizzy Spells	Yes	No	Thyroid Disease	Yes	No
Emphysema/Bronchitis	Yes	No	Tuberculosis	Yes	No
Fractures	Yes	No	Vision Problems	Yes	No

_____

_____

_____

PISGAH PHYSICAL THERAPY

PAIN/SYMPTOMS

On the Body Diagram above, indic
pain using the symbols below:

///	(STABBING)
XXX	(BURNING)
000	(PINS AND NEEDLES)
===	(NUMBNESS)

Is there anything else we should kı
symptoms?

_____
_____
_____
_____
_____
_____
_____

How did the pain start? (circle)

Suddenly	Pulling
Gradually	Injured at work
Lifting	Bending
No apparent reason	Other

What activities make the pain worse? (circle)

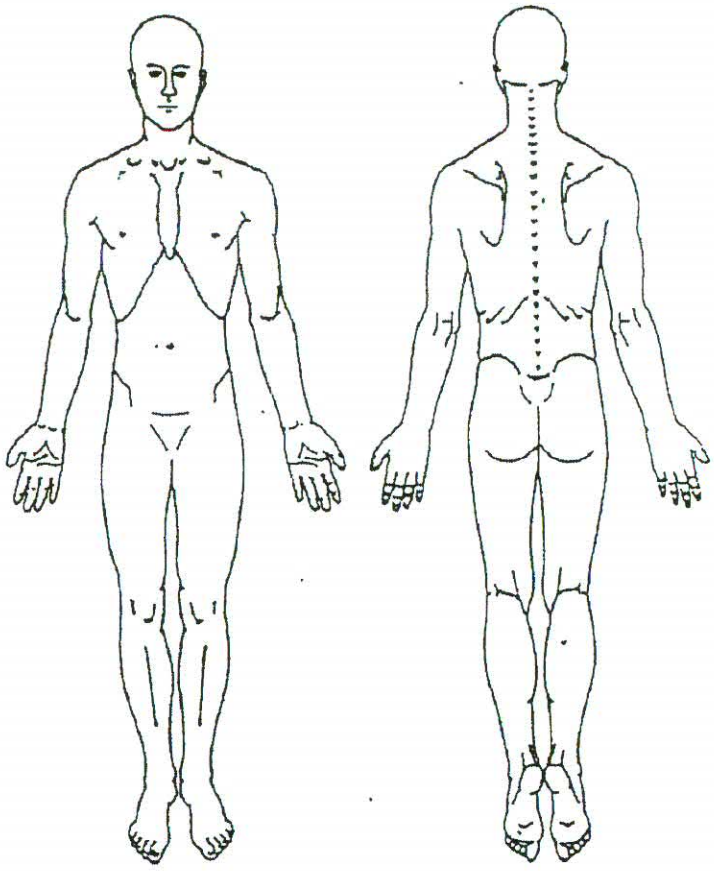
Exercise (during)	Bending forward
Exercise (after)	Bending backwards

How long have you had this pain?
( ) Years ( ) Months ( ) Weeks

How long have you had similar pain?
( ) Years ( ) Months ( ) Weeks

Please rate your pain on a scale from 1 – 10

1 2 3 4 5 6 7 8 9 10
1 No pain 5Strong 10Maximum



On the Body Diagram above, indicate your region of pain using the symbols below:

///	(STABBING)
XXX	(BURNING)
000	(PINS AND NEEDLES)
===	(NUMBNESS)

Is there anything else we should know about your symptoms?

_____
_____
_____
_____
_____
_____
_____