PROACTIVE Physical Therapy Centers

PATIENT REGISTRATION FORM

Patient Information

Legal Name		Preferred Name (if different)		M or F
Street Address		City/State/Zip	Social Security #	
Cell Phone Number	Work Phone Number		Date of Birth	
Email Address		*Occupation*		
Employer		*Work Phone Number*		

Emergency Contact

Name	
Phone Number	*Relationship*

Insurance Information

Primary Insurance	*Claims Phone Number*
Secondary Insurance	*Claims Phone Number*

Responsible Party *(if different than patient)*

Name		*Relationship*
Street Address	*City/State/Zip*	
Social Security Number	*Date of Birth*	*Phone Number*
Employer		*Work Phone Number*

How did you hear about ProActive Physical Therapy?

PROFESSIONAL SERVICES MUST BE PAID AT THE TIME THEY ARE RENDERED.

Assignment of Benefits: I hereby authorize payment directly to ProActive Physical Therapy Centers of benefits due me for services described above. I understand I am financially responsible for charges not covered by this authorization.

Release of Information: I hereby authorize ProActive Physical Therapy Centers to release any information required to process this claim form.

Signature of Patient or Authorized Representative	*Date*

Patient Information

Today's Date: ____/____/____

Name: ____ Height: ___________ Weight: __________lbs.

DOB: ____/____/____ Age: ________ Job description: ____

Referring Physician: ____

Describe how you injured yourself. If not from an injury, describe when and in what part of your body the pain or dysfunction started:

____

____

If you recently had surgery for this condition, please list date of surgery: _________________________

Describe the problems or limitations you are having now:

____

____

Have you had any previous treatment for this injury (i.e., medications, therapy, surgery)? If so, briefly describe when and the results of the treatment:

____

____

Are you receiving Home Health Services? (Does anyone come to your home to assist you?) ______________

Please list your current medications, if any (i.e., heart meds, pain medication, muscle relaxants.)

____

____

If you are allergic to any medications, please list

____

____

____

Please list any other medical conditions?

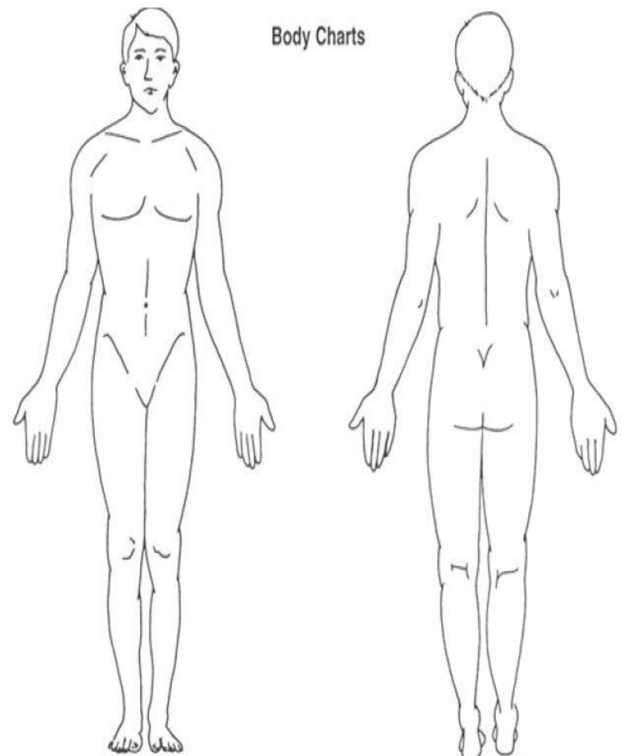
(i.e., pregnancy, heart problems, diabetes, seizures, etc.)

____

____

____

____



(Put an X at your area(s) of pain on the diagrams)

Is this injury **auto** or **work** related? ________________

If yes, please list date of injury: ____________________

Insurance Company______________________________

Referral from Doctor? If so, name the Doctor

____

Did Doctor mention us specifically by name? _____ If not, who at their office? _________________________

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CONSENT TO LEAVE PHONE MESSAGES/RELEASE OF INFORMATION

In order to protect patient confidentiality, ProActive Physical Therapy would like to obtain your consent to release and/or leave detailed messages. If we do not have a signed consent on file, we may only leave our name and phone number on an answering machine.

By completing the consent below you authorize ProActive Physical Therapy Centers to release information or leave a detailed message on voicemail or with a specific individual. In order for us to relate any of your medical information to anyone other than yourself, please check #3 below.

A. I give my consent to the staff of ProActive Physical Therapy Centers to release and/or leave messages regarding my care in the following situations: *(please check all that apply)*

1. ______ on voicemail (home and/or cell)
2. ______ on voicemail (work)
3. ______ with ______________________________ (relationship) __________________

____ ________________

Patient Name (Print) *Date*

____

Patient Signature

B. ______ I **do not** consent to voicemails and/or messages being left. Please contact me directly.

____ ________________

Patient Name (Print) *Date*

____

Patient Signature

PROACTIVE Physical Therapy Centers

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I understand that ProActive Physical Therapy Centers, LLC (referred to below as "the clinic") will use and disclose **health information** about Me in the course of providing physical therapy care to Me.

I understand that my **health information** may include information both created and received by the clinic, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnosis, treatments, procedures, and similar health-related information.

I understand that the clinic is permitted to **use and disclose** my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to/or consult and coordinate with other health care providers in the course of my treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care and
- Perform various office, administrative and business functions that support the clinics ability to provide me with appropriate care and arrange for payment.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request and that a copy or a summary of the most current version of the clinic's Notice of Privacy Practices in the effect will be posted in the waiting/reception area.

I understand that the Notice of Privacy Practices describes how I can exercise my right to ask that some or all of my health information not be used or disclosed, and I understand that the clinic is not required by law to agree with such requests.

By signing below, I agree that I have received or been offered a copy of this Notice of Privacy Practices.

Signature of Patient or Personal Representative:

____

Printed Name of Patient or Personal Representative:

____

Date: ____

Description of Representatives Authority:

____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ In emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

____