Patient Registration Form

Last Name: ________________________ First Name:________________________ MI: ______

Nickname:_____________________ Gender: Male / Female DOB: ___ / ___ / _____

Address: ____

City: ________________________________ State: __________________ ZIP: ________________

Employer Name: ________________________________ Occupation:______________________

Email Address: ____

Phone: (cell) ____________________ (h) _______________________ (w) __________________

Preference for contact during work hours: cell / home / work / email

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Emergency Contact:

Name: __________________________ Relationship:_______________ Phone: __________________

Referring Physician: _____________________________ Next Appt:_____________________

Insurance Carrier: ____________________ Subscriber Name: ____________________________

Relationship to Patient: ____________________________ Date of Birth: ____ /_____ /_______

Group #: __________________________ ID#:__________________________________

Reasn for visit: ____

____

Date of most recent Onset of Symptoms _________________ ☐ Condition is Chronic

Is your current condition related to a Surgery? ☐ Yes ☐ No

Is it a Related to an ***Auto Accident?*** *☐ Yes ☐ No Date of Accident:* ___________________

Is it a ***Work-Related Accident?*** *☐ Yes ☐ No Date of Accident:* __________________

Do you have a history of Falls? ☐ No ☐ Yes, Explain: ________________________________

Location of pain/symptoms: ____

On a scale of 0 – 10 rate you pain level (0=none, 10=extreme)

At Worst: _______ Current/At Rest: _______ At Best: _______

Please describe the type of pain you are experiencing (burning, sharp, dull/achy, throbbing, shooting, numbness/tingling) Other:____

What makes your symptoms WORSE? ____

What makes your symptoms BETTER? ____

Have you had PT, Chiropractic, or any other treatment for this condition? ☐ Yes ☐ No

If Yes, where?____

Have you undergone any type of diagnostic testing for this condition? ☐ X-Ray ☐ MRI

☐ Bone Scan ☐ CAT Scan ☐ Injections ☐ Othe__________________________________

What are your Goals of Therapy? ____

____

Is there anything else that you feel we should know about or have not asked? If so, please explain: ____

____

How did you hear about Integrated Physical Therapy, LLC: ________________________

____

I agree that the information given is complete and accurate to the best of my knowledge.

______________________________ ______________

Signature **Date**

Medical History

Are you currently or have you previously been diagnosed with any of the following? (Please check all that apply)

- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disorder
- ☐ Cancer
- ☐ Cardiac Conditions
- ☐ Cardiac Pacemaker
- ☐ Chemical Dependency
- ☐ Circulation Problems
- ☐ Currently Pregnant
- ☐ Depression
- ☐ Diabetes
- ☐ Dizzy Spells
- ☐ Emphysema/Bronchitis
- ☐ Fibromyalgia
- ☐ Fractures
- ☐ Gallbladder Problems
- ☐ Headaches
- ☐ Hearing Impairment
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ High/Low Blood Pressure
- ☐ HIV/AIDS
- ☐ Incontinence
- ☐ Kidney Problems
- ☐ Metal Implants
- ☐ MRSA
- ☐ Multiple Sclerosis
- ☐ Muscular Disease
- ☐ Osteoporosis/Osteopenia
- ☐ Parkinsons
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Smoking
- ☐ Speech Problems
- ☐ Strokes
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Vision Problems

Other: ____

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Surgical History

Body Region: ________________Surgery Type:____________________ Date:______________

Body Region: ________________Surgery Type:____________________ Date:______________

Body Region: ________________Surgery Type:____________________ Date:______________

Body Region: ________________Surgery Type:____________________ Date:______________

Current Medications

Drug:________________Dose:_______Frequency:_______ Route:_______Taking for:________________

Drug:________________Dose:_______Frequency:_______ Route:_______Taking for:________________

Drug:________________Dose:_______Frequency:_______ Route:_______Taking for:________________

Drug:________________Dose:_______Frequency:_______ Route:_______Taking for:________________

I. CONSENT FOR TREATMENT

I consent to treatment by Alix Sorrel, PT, DPT, OCS, PMA®– CPT as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

I consent to having my picture taken or videoed for objective analysis of my condition. This information will be used solely for the purpose of education of myself for my condition and to compare pre and post treatment outcomes. Any other use of this information will require your written consent.

II. CONSENT FOR RELEASE OF INFORMATION

I agree that Integrated Physical Therapy, LLC may provide information for my medical record to persons involved in my care. I authorize the release of medical information necessary to obtain payment of any benefits available to Integrated Physical Therapy, LLC for services rendered. I agree that Integrated Physical Therapy, LLC may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment.

My signature below indicates that I have been given the Notice of Privacy Practices for Integrated Physical Therapy, LLC.

III. PATIENT RESPONSIBILITY

Integrated Physical Therapy, LLC will file my insurance claims as a courtesy, and I understand that any quoted benefits given at the time of service are not a guarantee of payment. I authorize that direct payment of any benefits available to me be release to Integrated Physical Therapy LLC for services rendered.

I agree to pay Integrated Physical Therapy, LLC charges for services rendered to me during my course of treatment. I agree to pay those charges, which may not be paid by my health insurance and are my responsibility per my insurance benefit. If I do not pay for charges that are my responsibility, I agree to pay Integrated Physical Therapy, LLC collections costs including attorney and court fees.

I acknowledge and accept the terms and conditions set forth in Sections I, II, and III of this statement. Integrated Physical Therapy, LLC reserves the right to refuse service to anyone.

________________________________ _______________

Signature **Date**

Cancellation / No Show Policy – Physical Therapy

We honor and respect your time and our service to you is our highest priority. In return, we ask that you also respect our schedule so that we may be available not only to service you, but to also service others.

The unique opportunity for patients to work one-on-one with the certified Physical Therapist offered at Integrated Physical Therapy, LLC effectively gives you the best possible treatment and care. It is essential to attend the scheduled appointments requested by your physician. If you arrive late to your scheduled appointment your treatment time will be limited to allow for subsequent appointments to begin as scheduled.

Integrated Physical Therapy's PT patients are not charged for cancellations or no shows; however the owner retains the right to discharge the patient is either behavior compromises the plan of care or access to services for other patients. If you do not show up to your scheduled appointment on three or more occasions, Integrated Physical Therapy will reserve the right to discharge the patient and not allow future scheduling.

I, ___________________________________ have read the above stated policy and agree to be responsible for my health and for the results associated with my inability to adhere to this policy.

___________________________________ ____________________

Patient signature Date