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APOS/PHYSICAL/OCCUPATIONAL THERAPY Patient Registration

Date:_____ ID # _____

Last Name:_____ First Name: _____

Middle Name:_____ Date of Birth:_____ Gender: Female_____ Male _____

Address:_____ Apt or P.O. Box: _____

City:_____ State:_____ Zip:_____ SS# _____

Phone Numbers

Home Phone: (_____)_____-_____ Work Phone: (_____) _____-_____

Cell Phone: (_____)_____-_____ Email: _____

Emergency Contact:

Last Name: _____ First Name: _____

Phone: (_____)_____- _____ Relationship: _____

*Height_____ *Weight_____

Are you currently receiving PT at another office? YES/NO If Yes, do you Plan on switching to ProHealth? YES/NO

APOS treatment is not a standalone solution. We recommend that you be seen for physical therapy at our location or at another location more convenient if determined to be medically necessary by a physician

Problem Description: _____

Primary Care Doctor:_____ Phone: (_____)_____-_____

Referring Doctor:_____ Phone: (_____)_____- _____

Orthopedist:_____ Phone: (_____) _____- _____

Patient or Guardian Agreement:

I understand that I am responsible for any balance due, as well as all collection costs if applicable, **unless the FINANCIAL HARDSHIP FORM provided is completed and signed by all parties.**
I agree to comply with the terms and conditions as outlined in the Patient Initial Intake Form.

Notice of Privacy Practices:

I hereby acknowledge that I have been offered a copy of the Notice of Privacy Practices (you have the right to refuse to sign this acknowledge if you so choose).

Signature of Patient or Guardian: _____ Date _____/_____/_____

Patient Name: _____

Primary insurance

Insurance:_____ ID Number: _____

Primary Holder / Subscriber Name:_____ Date of Birth:_____/_____/_____

Primary Holder / Subscriber Name Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Secondary Insurance

Insurance:_____ ID Number: _____

Primary Holder / Subscriber Name:_____ Date of Birth:_____/_____/_____

Primary Holder / Subscriber Name Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Tertiary Insurance

Insurance:_____ ID Number: _____

Primary Holder / Subscriber Name:_____ Date of Birth:_____/_____/_____

Primary Holder / Subscriber Name Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Have you been seen this calendar year for Physical Therapy or Occupational Therapy? Yes/No If so, how many visits were used: _____

Patient or Guardian Agreement:

I authorize release of information requested by my insurance plan for payment.

I understand that I am responsible for any balance due, unless the Financial Hardship Form is completed and signed by all parties.

I agree to comply with the terms and conditions are outlined in the Patient Registration form.

Notice of Privacy Practices:

I hereby acknowledge that I have been offered a copy of the Notice of Privacy Practices. (You have the right to refuse to sign this acknowledgement if you so choose.)

Signature of Patient or Guardian:_____ Date_____/_____/_____

ProHealth & Fitness PT OT: Patient Initial Intake Form
Consent for the Release of Medical Information

I authorize any holder of medical or other information about me to release any information needed for this or related medical claim or my care with ProHealth and Fitness PT OT (PH&F PT OT). I hereby agree to the use and disclosure of my personal health information for the purposed noted in PH&F PT OT's *Patient Privacy and Rights* form. In doing so, I release PH&F PT OT from any and all legal liability that may arise from the release of such information. I agree that a copy of this authorization may be used in place of the original.

I understand that I have the right to revoke this consent by notifying PH&F PT OT in writing at any time, except for that action which has already taken place, and no further information will be released without an additional written authorization.

Patient Signature: _____ Date: _____/_____/_____

Insurance Agreement

You have the right for all insurance terms and payments to be explained to you before you begin treatment. **Medicare beneficiaries** should be aware that Medicare's policy allows for approximately 14 visits per calendar year; however, there are some circumstances where this 'threshold' can be extended or visits can be restarted after a period of time. Many insurance companies, including Medicaid and Medicare, often have a maximum number of visits that a patient can use each year, while some are based on medical necessity. If the information you provide on the initial intake paperwork is not accurate, it may result in payment denials from the insurance company and you being responsible for the visit cost. As a patient of PH&F PT OT, you are authorizing that payment of medical insurance benefits be made payable to PH&F PT OT for rehabilitation and/or healthcare services provided that a copy of your authorization may be used in place of the original. You are also responsible for the following:

- Providing us with all of your necessary insurance information
- Notifying us of any changes in your insurance policy or coverage prior to your next visit
- Notifying us of any services/treatment (nursing, physical therapy, occupational therapy, etc.) provided to you in your home by a Home Health Agency or at another facility; your visits with us may not be covered if your insurance if being used for these other services
- Any payments and/or fees not covered by your insurance, including, but not limited to, deductibles, co-pays and co- insurances, unless the Financial Hardship Form is completed and signed by all parties.
- **I authorize PH&F PT OT to send me reminders about my appointments via PHONE or TEXT (circle option)**

I acknowledge that I have received and consent to the policies disclosed in ProHealth and Fitness PT OT's Patient Rights and Privacy form. In addition, I have read and consent to all of the above insurance and payment policies of ProHealth and Fitness PT OT.

Patient Signature: _____ Date: _____/_____/_____

ProHealth & Fitness PT OT
MEDICAL HISTORY AND PHYSICAL CONDITION

NAME: _____ DATE: _____
CHIEF COMPLAINT:

_____

_____

1. Do you now have or have you in the past, had any of the following conditions:

Allergies	YES ☐	NO ☐	Hernia	YES ☐	NO ☐
Balance Problems	YES ☐	NO ☐	High Blood Pressure	YES ☐	NO ☐
Circulatory Problems	YES ☐	NO ☐	HIV/AIDS	YES ☐	NO ☐
Diabetes	YES ☐	NO ☐	Kidney Problems	YES ☐	NO ☐
Dizzy Spells	YES ☐	NO ☐	Nervous Disorder	YES ☐	NO ☐
Headaches	YES ☐	NO ☐	Pregnancy	YES ☐	NO ☐
Hearing Problems	YES ☐	NO ☐	Seizures	YES ☐	NO ☐
Heart Attack	YES ☐	NO ☐	Sensitive to heat/cold	YES ☐	NO ☐
Heart Disease	YES ☐	NO ☐	Vision Problems	YES ☐	NO ☐

If yes on any of the above, please explain and give approximate dates of occurrences:

_____
_____
_____

2. Have you had treatment for this/these problems before: YES ☐ NO ☐

_____
_____

3. Have you had any surgeries? YES ☐ NO ☐
If yes, what type of surgery did you have, who performed the surgery, and when was the surgery?

_____
_____
_____

4. Do you currently have any metal implants? YES ☐ NO ☐
5. Do you currently have a pacemaker? YES ☐ NO ☐
6. Do you have any communicable diseases? YES ☐ NO ☐

Please list **ALL** medications you are taking including Prescribed, Over-The-Counter, and Herbal

Name:_____ Dosage:_____Freq:_____
Name:_____ Dosage:_____Freq: _____
Name:_____ Dosage:_____Freq:_____
Name:_____ Dosage:_____Freq: _____
Name:_____ Dosage:_____Freq:_____

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Patient Copy: Privacy and Rights

ProHealth and Fitness PT OT (PH&F PT OT) follows the *Health Insurance Portability and Accountability Act (HIPAA)*, which establishes regulations for the use and disclosure of your Protected Health Information (PHI). Your PHI includes your personal medical records and payment history. While we use your health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide, PH&F PT OT may also:

- disclose your health information for public health purposes, audits, emergencies, and when required by law
- obtain any information necessary for your PT/OT treatment or a related medical claim from *other* holders of your PHI
- ask for your written authorization prior to disclosing/obtaining your information for any other purpose; you may revoke this authorization at any time if you wish to stop future disclosures
- use a copy of your authorization in place of the original
- make every effort to disclose only the minimum necessary information
- change our policy at any time and notify you that we have done so

As a patient of PH&F PT OT, you may:

- request a copy of your PHI or a list of any instances in which we may have disclosed your PHI for reasons other than treatment, payment, or administrative purposes
- request that we correct any inaccurate PHI
- request that we do not disclose your PHI for treatment, payment, or administrative purposes (except when specifically authorized by you, required by law, or in an emergency); we will consider these requests on a case-by-case basis, but we are not legally required to accept them
- contact our Privacy Officer, Dr. James Nussbaum, or send a written complaint to the US Department of Health and Human Services if you are concerned that your privacy rights have been violated in any way