East Athens Physical Therapy

PATIENT REGISTRATION

Today's Date: _____

Area of Injury to be treated: _____ Auto or Work Related? _____

Name: _____
First **MI** **Last**

Address: _____ _____
Street **Apt #** **P.O. Box**

_____
City **State** **Zip**

Cell Phone: _____ - _____ - _____ Home Phone: _____ - _____ - _____ Work Phone: _____ - _____ - _____

SSN: _____ - _____ - _____ Gender: _____ Marital Status: M S D W

Date of Birth: ____ / ____ / _____ E-Mail: _____

Emergency Contact: _____ Phone: _____

How did you hear about us? _____

Have you had physical therapy before? Y / N If yes, when? _____

Employer Information Occupation: _____

Employer: _____

Address: _____ _____
Street **P.O. Box**

_____
City **State** **Zip**

Physician Information

Primary Care Physician's Name: _____

Address: _____
Street **City** **State** **Zip**

Phone Number: _____ - _____ - _____ Fax Number: _____ - _____ - _____

Referring Physician's Name: _____

Address: _____
Street **City** **State** **Zip**

Phone Number: _____ - _____ - _____ Fax Number: _____ - _____ - _____

Date of return visit: ____ / ____ / _____

East Athens Physical Therapy

CONSENT TO TREATMENT

I hereby authorize the professional staff at **East Athens Physical Therapy** to examine and treat me with physical therapy for the injury for which I have been referred.

Patient Name Printed	**Patient Signature** Date
Parent or Guardian Name Printed Relationship	**Parent or Guardian Signature** Date
Staff Witness Signature	Date

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO HEALTH PROVIDER

Insurance Company / Companies Name(s): _____

I hereby instruct the above-named insurance company/companies to pay by check made to and mailed directly to: **East Athens Physical Therapy** for professional or medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy. I understand that **East Athens Physical Therapy** complies with HIPPA and will protect my Protected Health Information (PHI) and will use it as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed and full payment is received. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney for the purpose of securing payment under this policy of insurance or to any Medical Provider associated with my case to effectively treat me. The authorization is in effect until 90 days from the date the last bill is collected.

HIPAA REGULATIONS: A photocopy of this Assignment shall be considered effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance under the HIPPA guidelines.

Patient Name Printed	**Patient Signature** Date
Parent or Guardian Name Printed Relationship	**Parent or Guardian Signature** Date
Staff Witness Signature	Date

East Athens Physical Therapy

MEDICAL INFORMATION RELEASE FORM (HIPAA RELEASE FORM)

Name: _____ **Date of Birth:** _____ / _____ / _____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to ***(Please include first and last names)***:

[ ] Spouse / Partner : _____

[ ] Child(ren) : _____

[ ] Other : _____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated or revised by me in writing.

Messages and Appointment Reminders

Please call my: Home / Work / Cell Number: _____ - _____ - _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] other: _____

The best time to reach me is _____ between _____
Day Time

[ ] I wish to receive automated appointment reminders and other updates from *East Athens Physical Therapy*.

I authorize the company and their respective agents to contact me at the current or any future number that I provide for my cellular phone or other wireless device using automated dialing equipment of artificial or prerecorded voice or text messages.

I certify that the above information entered by myself, or an authorized representative is accurate, and I understand that it will remain in effect until terminated or revised by me or the authorized representative in writing.

_____ _____
Patient Name Printed **Patient Signature** Date

_____ _____
Parent or Guardian Name Printed Relationship **Parent or Guardian Signature** Date

_____ _____
Staff Witness Signature Date

East Athens Physical Therapy

MEDICAL HISTORY

Patient Name: _____ Next Doctor's Appointment: _____

Type of Surgery/Injury & Date/Onset: _____

Describe previous treatment for this condition: _____

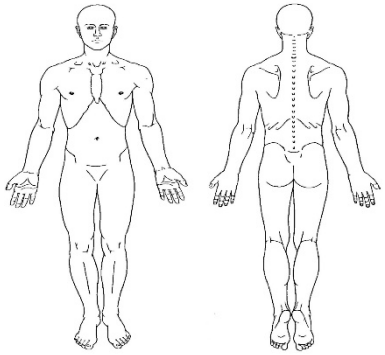
_____

Height: _____ Weight: _____
*(Required by 2019 insurance mandate)

Have you used any tobacco products in the last 6 months? **[Y / N]**
Would you be interested in receiving tobacco cessation intervention **[Y / N]**

Have you fallen in the last year? **[Y / N]** If yes, how many times? ____
*(Required by 2019 insurance mandate)

Have you had any imaging performed?
[ ] X-Ray [ ] CT Scan [ ] Ultrasound
[ ] MRI [ ] Doppler



Please mark the area(s) of concern

Have you recently noted any of the following:

[ ] Weight Loss / Gain	[ ] Nausea / Vomiting	[ ] Fatigue
[ ] Weakness	[ ] Fever / Chills / Sweats	[ ] Numbness / Tingling
[ ] Pregnant / IUD	[ ] Headaches	[ ] Changes in Vision / Hearing
[ ] Pain at Night	[ ] Cramps in legs when walking	[ ] Insomnia

Do you now or have you ever had any of the following:

[ ] Surgeries	[ ] Loss of Consciousness	[ ] Fractures
[ ] Sprains / Strains	[ ] Diabetes	[ ] Blood Pressure Problems
[ ] Heart Problems	[ ] Cancer	[ ] Motor Vehicle Accident
[ ] Circulation Problems / Clots	[ ] Asthma / Breathing Problems	[ ] Lung Disease
[ ] Easy Bruising / Bleeding	[ ] Leg / Ankle Swelling	[ ] Fainting
[ ] Indigestion / Heartburn	[ ] Urinary Problems / Infections	[ ] Allergies / Skin Sensitivity
[ ] Rheumatoid Arthritis		

[ ] Any previous injury that may affect current care: _____

Explain and give dates for any items indicated above: _____

_____

Are you currently taking medications? Y / N
*(Required by 2019 insurance mandate)

Name and dosage of medications: _____

_____

_____

Type of Pain: Sharp / Burning / Aching / Tingling / Numbness / Other: _____

Rate your pain: *At worst:* 1 2 3 4 5 6 7 8 9 10 *At best:* 1 2 3 4 5 6 7 8 9 10 *Current:* 1 2 3 4 5 6 7 8 9 10
*(Required by 2019 insurance mandate)

_____ _____

Patient or Representative Signature Date