East Athens Physical Therapy

PATIENT REGISTRATION

Area of Injury to be treated____________________ Auto or Work related?_______________

Today's Date ____________

Name ____
First MI Last

Address ______________________________________ ____________
Street Apt # PO Box

____
City State Zip

Home Phone ____-____-______ Work Phone_____-_____-_______ Cell Phone_____-_____-______

SS# _______-_________-____________ Male or Female Marital Status M S D W

Date of Birth: ____________________ E-Mail: ______________________________

Emergency Contact: ______________________________________ Phone: ______________

How did you hear about us? ____

Employer Information **Occupation**______________________

Employer ____

Address ______________________________________ ____________
Street Apt # PO Box

____
City State Zip

Physician Information

Primary Care Physician Name ____

Address ____
Street City ST Zip

Phone ______-________-____________ Fax ______-________-__________

Referring Physician Name ____

Address ____
Street City ST Zip

Phone ______-________-____________ Fax ______-________-__________

Date of your return visit? ________________

Have you had physical therapy before? ___ **No** ___ **Yes** **If yes, when?**________________

Health Insurance Information

Primary Insured Name ____________________________ Insured Date of Birth ________________

Relationship to insured ___________________________ Insured Phone # ____________________

Insured Address if Different from Patient:

Address ____
Street City ST Zip

Health Insurance Co Name ______________________________ Ins Phone #______________________

Address ____
Street City ST Zip

Group Number___________________________ ID Number______________________

Contact Name ____

East Athens Physical Therapy

Health Insurance Information

Primary Insured Name ______________________ Insured Date of Birth ______________

Relationship to insured ______________________ Insured Phone # ______________

Insured Address if Different from Patient:

Address ____
Street City ST. Zip

Health Insurance Co Name ______________________ Ins Phone # ______________

Address ____
Street City ST Zip

Group Number ______________________ ID Number ______________

Contact Name ____

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.

X ______________________ X ______________________
Patient Signature Date

X ______________________ ______________________
Patient Printed Name Staff Witness Signature

______________________ ______________________
Parent or Guardian Signature Date

______________________ ______________________
Parent or Guardian Printed Name Staff Witness Signature

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 out 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.

HIPPA 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.

X ______________________ X ______________________
Patient Name (Printed) Date **Patient Signature**

______________________ ______________________
Parent or Guardian (Printed) Relationship **Parent or Guardian Signature**

Witness ______________________ Date ______________________

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:

[ ] Spouse ____

[ ] Child(ren) ______________________________________

[ ] Other ____

[ ] Information is not to be released to anyone.

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

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____________________

If unable to reach me:

[ ] you may leave a detailed message

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

[ ] ____

The best time to reach me is (day)______________ between (time) ______________

I authorize East Athens Physical Therapy 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 telephone dialing equipment of artificial or pre-recorded voice or text messages.

Signed: ____ Date: _____/_____/_____

Witness: ____ Date: _____/_____/_____

East Athens Physical Therapy (EAPT) - MEDICAL HISTORY

Patient Name____ Next Doctor's Appointment__________________________

Type of Surgery/Injury & Date/Onset______________________________

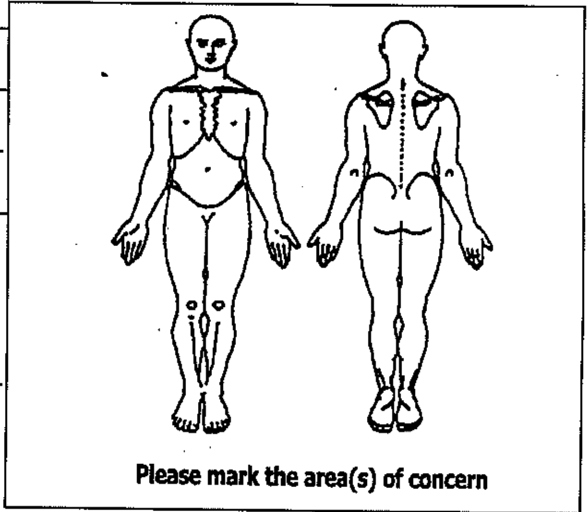
Describe previous treatment for this condition______________________________

____

*(Required by 2019 insurance mandate) Height___________Weight______________

For any questions regarding nutrition please contact:
Piedmont's Outpatient Nutrition Services at 706-475-1000 option 2

*(Required by 2019 insurance mandate)
Have you fallen within the last year? _____ If yes how many times _____



Please mark the area(s) of concern

Have you had any imaging performed:

- ☐ X-Ray
- ☐ MRI
- ☐ CT Scan
- ☐ Doppler
- ☐ Ultrasound

Have you recently noted:

- ☐ Weight Loss / Gain
- ☐ Weakness
- ☐ Pregnant / IUD
- ☐ Pain at Night
- ☐ Nausea / Vomiting
- ☐ Fever / Chills / Sweats
- ☐ Headaches
- ☐ Cramps in Legs When Walking
- ☐ Fatigue
- ☐ Numbness / Tingling
- ☐ Change in Vision / Hearing
- ☐ Insomnia

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

- ☐ Surgeries
- ☐ Sprains / Strains
- ☐ Heart Problems
- ☐ Circulation Problems / Clots
- ☐ Easy Bruising / Bleeding
- ☐ Indigestions / Heartburn
- ☐ Rheumatoid Arthritis
- ☐ Loss of Consciousness
- ☐ Diabetes
- ☐ Cancer
- ☐ Asthma / Breathing Problems
- ☐ Leg / Ankle Swelling
- ☐ Fainting
- ☐ Fractures
- ☐ Blood Pressure Problems
- ☐ Motor Vehicle Accident
- ☐ Lung Disease
- ☐ Urinary Problems / Infections
- ☐ Allergies / Skin Sensitivity
- ☐ Any previous injury that may affect current care ______________________________

Explain and give approximate dates for any items indicated above ______________________________

____

*(Required by 2019 insurance mandate) Are you currently taking medications? Yes / No

*(Required by 2019 insurance mandate) Name and dosage of Medication ______________________________

____

____

____

____

____

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

*(Required by 2019 insurance mandate)
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

______________________________________ ____________________

Patient or Personal Representative Signature **Date**