Registration Form

Today's Date_____ Preliminary Diagnosis _____

Last Name _____First Name _____ Middle Initial_____

Home Phone _____Work Phone _____Cell Phone_____

(Please circle the phone number which is best to reach you during the day).

Mailing Address_____City_____

State _____Zip _____Date of Birth_____

E-Mail Address: _____ Male or Female (circle)

Chose clinic because/Referred to clinic by (please Circle answer): Physician, Family member, Friend, Insurance Co.,

Other_____

Have you received Physical, Occupational, or Speech therapy services in the current calendar year? ____ Yes ____No

If yes, where? _____Phone_____

Start Date _____ End Date _____

Are you currently receiving home health services? ____ Yes ____ No

Employer Name_____

Spouse's Name _____Work Phone_____

Emergency Contact_____Relationship_____Phone_____

Family Physician (PCP)_____

Financial Information (If patient is a minor, please complete this section)

Name of Responsible Party_____Relationship_____

Address_____Phone_____

Basic Workman's Comp./Auto Insurance/Injury Information (Please complete if injury is work or auto related.)

Date of Injury (or onset of pain): _____

Type of Accident: Job: _____ Contact Person: _____

Auto: _____ Claim #: _____Contact Person: _____

Patient Intake Questionnaire

Date: _____

Patient's Name: _____

Date of Birth: _____ Age: _____ Sex: _____

Current complaint…

1. What is the complaint that brought you here? _____ Date it began/ became worse?_____

2. What caused this complaint? _____

3. Does it affect your activity choice, tolerance or efficiency? Yes or No? If "yes", what activities? _____

4. What makes this complaint better? _____

Worse? _____

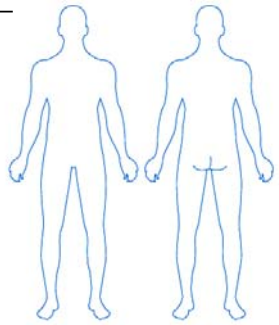
5. Does this complaint affect your comfort, mood or ability to sleep? Yes of No?

6. What symptoms are you experiencing with this complaint?

[] Swelling [] Loss of balance/ coordination [] Loss of motion [] Numbness [] Weakness [] Tingling

[] Other _____

[] Pain: Draw pain areas on body diagram ⇨



7. How frequent are the symptoms experienced? [] constant [] intermittent

8. How much pain are you experiencing? [] None [] Mild [] Moderate [] Severe [] Very Severe

9. What tests have you had for this complaint?

[] X-ray [] CAT scan [] MRI [] Myelogram [] Bone Scan

10. What treatment have you had for this complaint? [] Physical Therapy [] Occupational Therapy

[] Athletic Training [] Chiropractic [] Alternative Medicine (specify)_____

11. Is this complaint work related? [] yes [] no If "yes", Employers name:_____

Occupation: _____ Work Status: [] F-Time [] P-Time [] Working [] Medical Restrictions/ Leave

Last Date Worked: _____

12. Is this complaint auto related? [] yes [] no

General Health…

1. Check all that apply:

[] Arthritis [] Heart Disease [] Stomach Disorder [] Thyroid Problems [] Cancer [] High Blood Pressure [] Anxiety

[] Panic Attack [] Pace Maker [] Diabetes [] Depression [] Lung Disease [] Hearing Problems [] visual problems

[] Learning Problems [] Pregnant [] Bowel or bladder control [] Smoke [] Osteoarthritis

2. Please list surgeries: _____

_____

3. Please list all allergies: _____

_____

4. Please list medications you are currently taking: _____

_____

_____

_____

Elk Rapids Physical Therapy Financial Policy

Thank you for choosing Elk Rapids Physical Therapy - we are committed to providing you with the best possible service and ask that you read and acknowledge the terms of our Financial Policy.

PAYMENT: All payments including copay, coinsurance and deductible are due on the date of service. We accept cash, checks, Visa, MasterCard, and Discover credit cards. As a courtesy to our patients, we will contact your insurance provider to verify your physical therapy coverage. We cannot, however, guarantee the accuracy of the information we receive from your insurance provider.

COINSURANCE/DEDUCTIBLE: If you have a plan with coinsurance percentage or deductible which has not been met, we will estimate the coinsurance/deductible amounts based on what we have been lead to expect your insurance company will pay. Please note that any payment made on the date of service is considered a **DEPOSIT** toward your **ESTIMATED** patient balance. Because this is an estimate, there is always the possibility that you may be either responsible for an additional balance or due a refund. If a refund is due – it will be promptly provided. If it turns out that your insurance company payment is less than expected – you are responsible to promptly pay any additional balance due. An unpaid balance over 30 days past due may be referred to a collection agency.

***I have read and understand the above. Please initial here: _____**

INSURANCE: We encourage you to call your insurance company with any specific questions related to your policy's outpatient physical therapy benefits such as deductible, copayment, coinsurance, visit limitations i.e., sharing of outpatient benefits with acupuncture, chiropractic or occupational care, effective annual calendar renewal date, or any pre-authorization requirements.

Elk Rapids Physical Therapy cannot assume responsibility for incorrect information provided to us concerning your insurance policy. Our courtesy verification of eligibility and benefits does not guarantee that your insurance company will pay for all services provided. Your insurance policy is a contract between you and your insurance company. You are responsible for knowing your level of coverage and are ultimately responsible for the full payment of your bill.

CANCELLATION POLICY: Therapist time is reserved for your appointment – if you are unable to keep your appointment we kindly ask that you provide us with 24-hour advance notice of cancellation. If you fail to cancel a scheduled appointment 24 hours in advance, or "no-show" an appointment, we reserve the right to assess a **$50.00 cancellation fee**.

I have read and understand the above Elk Rapids Physical Therapy Financial Policy, agree to the terms, and understand that I am ultimately responsible for payment of the health care services provided.

_____ _____

Printed Patient Name Printed Name of Guarantor (if applicable)

_____

Signature of Patient (or Guarantor) Date

Elk Rapids Physical Therapy Office Policies

Consent for Care and Treatment: I, the undersigned, do hereby agree and give my consent for Elk Rapids Physical Therapy to provide physical therapy care and treatment necessary and proper in evaluating and treating my physical condition.

Consent for Treatment of a Minor: As parent and/or legal guardian, I authorize Elk Rapids Physical Therapy to treat the minor patient named in the attached consent form while I am not present.

Benefit Assignment/Release of Information: I hereby assign all medical benefits to which I am responsible to Elk Rapids Physical Therapy. I hereby authorize Elk Rapids Physical Therapy to release all information necessary, including medical records, to secure payment.

Workers' Compensation Claims: If I claim Workers' Compensation benefits and am subsequently denied such benefits, I may be held responsible for the total amount of charges for services rendered

_____ _____

Patients Signature Date

ELK RAPIDS PHYSICAL THERAPY

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

ELK RAPIDS PHYSICAL THERAPY'S LEGAL DUTY

Elk Rapids Physical Therapy is required is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Elk Rapids Physical Therapy uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Elk Rapids Physical Therapy may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Elk Rapids Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Elk Rapids Physical Therapy's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop further disclosures at any time.

Elk Rapids Physical Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Elk Rapids Physical Therapy will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Elk Rapids Physical Therapy may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our owner(s) at the address listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. For further information on Elk Rapids Physical Therapy's health information practices, or if you have a complaint, please contact the following:

Elk Rapids Physical Therapy
128 Ames Street Elk Rapids, MI 49629
231.264.6682

PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand Elk Rapids Physical Therapy's Notice of Information Practices. I understand that Elk Rapids Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that if I notify the practice, I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations. I also understand that Elk Rapids Physical Therapy will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions. I hereby consent to the use and disclosure of my personal health information for purposes as noted in Elk Rapids Physical Therapy's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____
Patient Name

_____
Signature

_____
Signature of Parent/Guardian
(If patient is a minor)

_____
Date