Patient Registration

Date: _____

Smith Physical Therapy & Wellness, P.C.

Patient Demographic Information:

First Name: _____ MI: _____ Last Name: _____

Nickname: _____ Gender: ☐ Male ☐ Female ☐ Unknown

Date of Birth: _____ / _____ / _____ Marital Status: ☐ Married ☐ Single ☐ Other

Employment Status: ☐ Employed Full-time ☐ Employed Part-time ☐ Student ☐ Retired ☐ Other

Employer Name: _____ Occupation: _____

Patient Contact Information:

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Primary Contact #: ☐ Home ☐ Work ☐ Cell E-mail: _____

Emergency Contact: _____ Phone #: _____ Relation: _____

Responsible Party: *(This section refers to the person/party who should receive the bill)*

Relation to Patient: ☐ Self (skip to next section) ☐ Spouse ☐ Parent ☐ Other _____

Guarantor Name: _____ Date of Birth: _____ / _____ / _____

Home #: _____ Work #: _____ Cell #: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Insurance Information:

Primary Insurance Company: _____

Subscriber's Relation to Patient: ☐ Self (skip to next section) ☐ Spouse ☐ Parent ☐ Other

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

Subscriber Address: _____ Phone #: _____

Secondary Insurance Company: _____

Subscriber's Relation to Patient: ☐ Self (skip to next section) ☐ Spouse ☐ Parent ☐ Other

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

Subscriber Address: _____ Phone #: _____

Home Health Services: Are you currently receiving any services from a home health agency? ☐ Yes ☐ No

If yes, Name of company: _____

How did you hear about us? ☐ I am a former Patient ☐ Referring Physician ☐ Friend/Relative

☐ Online Search ☐ Other: _____

Medical History

Smith Physical Therapy & Wellness, P.C.

Patient Name: _____ **Today's Date:** _____

Information Relating to Current Episode of Care → Date of Injury: _____ Date of Surgery: _____

Referring Physician: _____ Next Appt w/ Physician: _____

Age: _____ Height: _____ Weight: _____

How would you rate your current health status? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you ever had physical therapy for this same or similar condition? ☐ Yes ☐ No

If yes, when, where and how long? _____

Is there any history of falls? ☐ Yes ☐ No → If yes, how often? _____

Select any that apply:

☐ Alzheimer's	☐ History of Cancer	☐ Asthma/Emphysema
☐ Cardiovascular Disease	☐ Huntington's	☐ Current Pregnancy
☐ Cauda Equina Syndrome	☐ Immunosuppression	☐ High Cholesterol
☐ Cerebral Vascular Accident	☐ Lupus	☐ Pacemaker
☐ Current Infection	☐ Muscular Dystrophy	☐ Seizures
☐ Diabetes Mellitus Type 1	☐ Obesity	☐ Thyroid Disease
☐ Diabetes Mellitus Type 2	☐ Osteoarthritis	☐ Allergy to latex or adhesive
☐ Fibromyalgia	☐ Parkinson's	☐ Other allergies: _____
☐ Fracture or Suspected Fracture	☐ Rheumatoid Arthritis	_____
☐ High Blood Pressure	☐ Traumatic Brain Injury	_____

Past Surgical History:

Hip Replacement? ☐ Left ☐ Right Date: _____ Other Surgeries & Date Estimates:

Knee Replacement? ☐ Left ☐ Right Date: _____ _____

Shoulder Repl.? ☐ Left ☐ Right Date: _____ _____

Fusion? ☐ Cervical ☐ Spinal Date: _____ _____

Medications & Dosages → Please list your medication(s) and dosages below ☐ **Attached is copy of medications**

_____ _____

_____ _____

_____ _____

Ob/Gyn History (Female - Pelvic Floor patients only)

Y / N Childbirth vaginal deliveries # ____	Y / N Prolapse or organ falling out	Y / N Pelvic pain
Y / N Episiotomy # _____	Y / N Vaginal Dryness	Y / N Painful vaginal penetration
Y / N C-Section # _____	Y / N Painful Periods	
Y / N Difficult childbirth # _____	Y / N Monopause – When? _____	

Add'l Information → Please add any additional medical history or conditions you would like the therapist to know about:

_____

_____

I verify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature: _____ **Date:** _____

Consent for Treatment/Privacy Policy/Assignment of Benefits

The undersigned, being the patient and/or guaranteeing party to the above named account hereby acknowledges and agrees to the following:

I. **CONSENT FOR TREATMENT:** I hereby consent to the evaluation, rehabilitation and incidental medical services provided by Smith Physical Therapy & Wellness, P.C. within this facility. I understand that my consent may be revoked, in writing, at any time. However, such revocation does not release any financial obligation for services already rendered. I know and agree that Smith Physical Therapy & Wellness, P.C. is not responsible for lost or damage to personal valuables.

Patient's Signature: _____ Date: _____

CONSENT FOR TREATMENT OF A MINOR: I, the undersigned, attest that I am the custodial parent or legal guardian of the below referenced minor, and hereby authorize Smith Physical Therapy & Wellness, P.C. to administer treatment, as it so deems necessary. I hereby authorize any treatment deemed appropriate by the therapists.

Patient's (Minor) Name: _____
Parent/Guardian Name (printed): _____
Parent/Guardian Signature: _____ Date: _____

II. **RELEASE/OBTAIN INFORMATION:** The undersigned understands that Smith Physical Therapy & Wellness, P.C. may release to any insurance carrier represented as contractually responsible for payment in whole or in part of the patient's health care bill, such information as is deemed as minimally necessary for the proper and accurate processing of such healthcare claims. Further, the undersigned understands the Smith Physical Therapy & Wellness, P.C. may provide to outside healthcare providers/services such information as is necessary to facilitate proper healthcare, limited only to that which is deemed minimally necessary to execute referrals, etc. on behalf of the patient. In addition, by copy of this document the patient consents to the release of prior medical records from referring physicians, hospitals, nurses or other entities, which have records necessary for proper evaluation and treatment of the patient.

III. **PRIVACY STATEMENT:** The undersigned hereby acknowledges that he/she has received a copy of the Notice of Privacy Practices. Smith Physical Therapy & Wellness, P.C., will administer our patient records in a confidential manner and in compliance with the Health Insurance Portability and Accountability Act. A separate authorization must be executed for the non-routine release of Protected Health Information. Patient information shall not be sold to any outside marketing firms, and will not be included in any medical studies without the explicit and separate authorization of the patient.

I acknowledge and accept the terms and conditions set forth in Sections II and III of this policy statement.

Patient/Legal Guardian Signature: _____ Date: _____

IV. **STATEMENT OF FINANCIAL RESPONSIBILITY:** In consideration of medical treatment and service provided to the above-named patient, the patient or the undersigned guarantor, unconditionally guarantees payment in full to Smith Physical Therapy & Wellness, P.C. Smith Physical Therapy & Wellness, P.C. agrees to abide by the terms and conditions set forth in individual managed care contracts with which the patient and physician both participate. Patients covered by insurance that do not have a managed care contract with Smith Physical Therapy & Wellness, P.C. understand that Smith Physical Therapy & Wellness, P.C. will submit claims for processing. However, the patient/guarantor is ultimately responsible for payment of the entire account balance regardless of insurance coverage or insurance benefit determination. Should an insurance carrier not pay on a claim within the mandatory 45-day state limit, the balance due will be the responsibility of the patient/guarantor. All co-pays are due at the time of service. The patient/guarantor understands he/she is responsible for providing accurate and complete billing information.

V. **ASSIGNMENT OF INSURANCE BENEFITS:** The undersigned hereby authorizes any insurance carrier represented as contractually responsible for payment in whole or in part of the patient's healthcare bill, including Personal Injury Protection or Medical Payment coverage, to pay directly to Smith Physical Therapy & Wellness, P.C. proceeds and benefits payable to me. Additionally, I agree than any payments shall be applied toward any settlement or judgment I receive under any auto liability or uninsured/underinsured motorists coverage provided by Medical Payments coverage.

VI. **UNDERSTANDING OF BENEFITS RECEIVED:** The undersigned understands that as a courtesy to the patient, the staff at Smith Physical Therapy & Wellness, P.C. uses the insurance information provided by the patient and the referring doctor to check insurance benefits for the treatment of physical therapy. The benefits that are given to the patient during their physical therapy visits are estimated benefits based on the information we have received from the patient's insurance company. If the amount charged to the patient during their physical therapy visits differs from what the patient's insurance company states they owe, Smith Physical Therapy & Wellness, P.C. has the right to bill the patient for the remaining balance or refund money for overpayment.

I acknowledge and accept the terms and conditions set forth in Sections IV, V, and VI of this policy statement.

Patient/Legal Guardian Signature: _____ Date: _____

Pelvic Floor Exam Consent Form

I understand that I will have the opportunity to give/revoke my consent at each treatment session.

I understand that I may have a person of my choice accompany me during the evaluation, and that the exam will occur in a clean, private, and secure area.

I understand that I will be required to disrobe for the exam and that appropriate draping and coverings will be provided.

I will communicate relevant medical history information to the therapist including, but not limited to, medication use, IUDs (or other implants), pre-existing urogenital infection or known sexually communicable diseases.

I understand that this examination is performed by observing, palpating or inserting a gloved finger into the perineal region including the vagina and/or rectum. The evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility and function of the pelvic floor region.

Treatment may include, but is not limited to the following: observation, palpation, use of vaginal weights, vaginal or rectal sensors for biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises, soft tissue and/or joint mobilization and educational instruction.

Potential risks: I may experience an increase in my current level of pain or discomfort, an aggravation of my existing injury or minor bleeding. These effects are usually temporary; if they do not subside in 1-3 days, I agree to contact my therapist or physician.

Potential benefits: I may experience an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

By signing below, I acknowledge that I have read and understood the above information.

_____	_____	_____
Patient Name	Signature	Date

Late, No-Show, Cancellation and Re-scheduling Policies

Smith Physical Therapy & Wellness, P.C.

Smith Physical Therapy & Wellness, P.C. strives to provide each patient with the highest quality of care while attempting to accommodate your schedule for your convenience. Therefore, we provide reserved time slots for each patient with a specific professional to minimize your waiting time and assure continuity of your treatment. Your consistent attendance of the planned treatment regimen is paramount to your full recovery.

We ask your full cooperation with the following policy; If you do not agree with the following terms, please be aware that any late cancellation or "No Show" without adequate reasoning and/or notification may result in discontinuation of treatment.

- We request a *24-hour notice* in the event of a cancellation**. If notice is not given, this will result in a $25 fee that will be collected upon arrival at the next scheduled appointment.**
- Failure to show up for an appointment ("NO SHOW") without notifying us at least 24 hours prior will result in a **$25 fee** being charged for that appointment. Furthermore, 2 consecutive no-shows will possibly result in the cancellation of all remaining scheduled appointments and the referring doctor will be notified.
- If you are more than 15 minutes late for your appointment and fail to notify us, there is a possibility that your treatment time will be cut to allow for the next scheduled patient to start their appointment on time.
- All patients, regardless of insurance/third party payor, will be responsible for the fee.

Should you need to cancel or change your appointment, please call us directly at (361) 528-3018. **If**, in fact, an emergency did occur that kept the patient from being able to contact our office, we will consult with management and leave the fee up to their discretion. Again, this policy is to assist our facility to offer you a more efficient operation.

We look forward to having the opportunity to work with you and to assist you in your current therapy needs.

Sincerely,

Kobi Smith, PT, DPT
Smith Physical Therapy & Wellness

Patient/Guardian Signature: _____ Date: _____