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: _____ _____

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

_____

_____

_____

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

_____ _____

_____ _____

_____ _____

_____ _____

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

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

Worker's Compensation Information

Smith Physical Therapy & Wellness, P.C.

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

Employer Information:

Name of Employer: _____

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

Contact Person: _____ Phone #: _____

Employer Insurance Information:

Insurance Carrier: _____ Phone #: _____

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

Claim #: _____

Adjuster Name: _____ Adjuster Phone #: _____

Job Description:

Job Title:_____

How long have you been at your current job? _____

Are you presently working? ☐ Yes ☐ No

→ **If yes,** ☐ Full Duty _____ hours daily

☐ Modified Duty _____ hours daily

What restrictions, if any, have been put in place? _____

_____

_____

_____

→ **If no,** how long have you been off from work? _____

What physical requirements of your job are you particularly concerned with? _____

_____

_____

_____

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

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: _____

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: _____