Advantage PT
Physical Therapy and Sports Rehabilitation

REGISTRATION FORM

(Please Print)

Date:

PATIENT INFORMATION

Last Name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Other ☐		
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former Name):	Birth date:	Age:	Sex: ☐ M ☐ F
Street address:	Social Security no.:	Home phone : ( )			
P.O. box:	City:	State:	ZIP Code:	Mobile Phone: ( )	
Occupation:	Employer:	Work phone: ( )			
Spouse's Name:	Your Email Address:				
May we email you information such as appointment times, exercise handouts, our newsletter or requests for information? ☐ Yes ☐ No	NOTE: Your email address will be kept confidential and only used by Advantage PT for Physical Therapy related correspondence.				
Chose clinic because/referred to clinic by (Please check one box):	☐ Dr.	☐ Insurance plan	☐ Hospital		
☐ Family	☐ Friend	☐ Close to home/work	☐ Internet	☐ Other:	

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone : ( )		
Is this person a previous patient here? ☐ Yes ☐ No					
Please indicate primary insurance	☐ Premera	☐ Aetna	☐ Cigna/Great West	☐ First Choice	☐ Regence
☐ LifeWise	☐ United Healthcare	☐ Medicare	☐ L&I	☐ Other:	
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:		
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐Other:	

IN CASE OF EMERGENCY

Name of local relative or friend:	Relationship to patient:	Home phone: ( )	Work phone: ( )

The above information is true to the best of my knowledge. I certify that I (or my dependent) assign directly to Advantage Physical Therapy all insurance benefits, if any, otherwise payable to me for services rendered. I authorize my insurance benefits be paid directly to Advantage Physical Therapy. **I understand that I am financially responsible for any and all charges not paid by my insurance.** I also authorize Advantage Physical Therapy or my insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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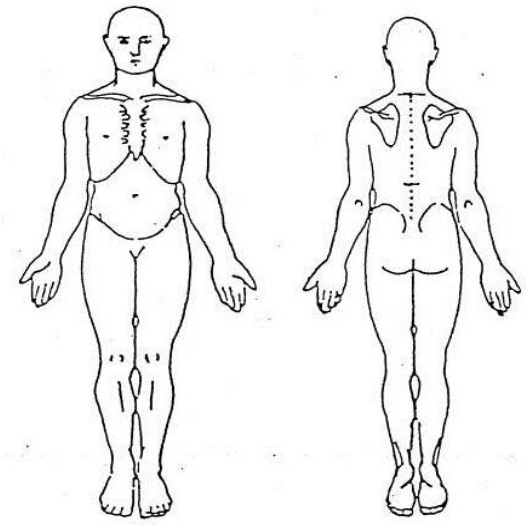
Patient's Name:	Age:
Type of Injury/Condition:	Onset/Injury Date:

Occupation:
Sports Activities / Exercise:
Type of Surgery & Date:
Next Doctor's Appointment:
Describe previous treatment for this condition:
Please check any tests you have had: ☐ X-Ray ☐ MRI ☐ EMG ☐ CT Scan ☐ Ultrasound

On the diagram below, please mark with an 'X' the area(s) you are being treated for.



If so, what were the findings?

Have you recently noted:		
☐ Unexpected Weight Loss / Gain	☐ Numbness / Tingling	☐ Pain with Coughing / Sneezing
☐ Nausea	☐ Fainting	☐ Changes in Bowel / Bladder Habits
☐ Vomiting	☐ Pain at Night	☐ Change in Vision or Double Vision
☐ Dizziness	☐ Difficulty Swallowing / Speaking	☐ Numbness / Tingling in the Saddle Area
☐ Fatigue	☐ Stumbling While Walking	☐ Numbness / Tingling in both Hands and Feet at the Same Time
☐ Weakness		

Do you have now or have you ever had any of the following?		
☐ Surgeries	☐ Pregnancy	☐ Circulation Problems / Clots
☐ Sprains / Strains	☐ Diabetes	☐ Asthma / Breathing Problems
☐ Fractures	☐ Blood Pressure Problems	☐ Osteoporosis / Osteopenia
☐ Loss of Consciousness	☐ Heart Problems	☐ Easy Bruising / Bleeding
	☐ Cancer	☐ Indigestion / Heartburn
	☐ Motor Vehicle Accident	☐ Allergies / Skin Sensitivity

Please explain and give approximate dates for any items listed above:

Are you currently taking any medications?	☐ Yes	☐ No	Name or Type of Medication:

Type of Pain:	☐ Sharp	☐ Burning	☐ Aching	☐ Tingling	☐ Numbness	☐ Other

Rate your Pain (1= minimal, 10 = Severe)	Now _____ (0 to 10)	At its Worst _____ (0 to 10)	At its Best _____ (0 to 10)

What are your goals from Physical Therapy?

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Cancellation Policy

Thank you for making Advantage Physical Therapy and Sports Rehabilitation your choice for therapy services. **In order to help you, we have found that consistent attendance is the key to our patients' success. Your therapist schedules 60 minutes of their day specifically for you and therefore it is important that you utilize this dedicated time.**

For this reason, all therapy sessions are important and cancellations/no shows are discouraged. Please take a moment to review the guidelines we have put in place to ensure that you get the most out of your experience at Advantage Physical Therapy:

- In the event that you will be late for an appointment, **please call as soon as possible** to notify us of your expected arrival time. Please note that you may be asked to wait until your therapist is available or to reschedule.
- **Please give at least 24 hour notice in the event of a cancellation**. If you are unable to give 24 hour notice, please contact us as soon as possible.
- **A Late Cancellation (within 24 hours) and all No Shows will be charged $50 for missed treatment sessions.**
- Cancellation/No Show fees are not covered by insurance and must be paid before future services are rendered.
- Cancellations due to illness or family emergency are excluded from this policy.

I understand Advantage Physical Therapy's cancellation and No Show policy and acknowledge that it is my responsibility to plan appointments accordingly and notify Advantage if I cannot fulfill my scheduled appointments.

Patient Signature: _____ Date: ___/___/_____

Financial Liability

Your health insurance plan is a contract between you and the insurance company. We are not party to the contract. Not all medical services are covered in all contracts. We will make every attempt to obtain payment through your insurer, but you responsible for any and all charges not covered by your health insurance. By signing below, you are acknowledging your responsibility for any uncovered services and charges.

_____ ___/___/_____
Signature Date

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of Advantage Physical Therapy and Sports Rehabilitation's Notice of Privacy Practices and that I have read (or had the opportunity to read if I chose) and understand the Privacy Practices.

_____ ___/___/_____ _____
Patient Name (please print) Date Parent or Authorized Representative (if applicable)

_____
Signature