

REGISTRATION FORM

(Please Print)

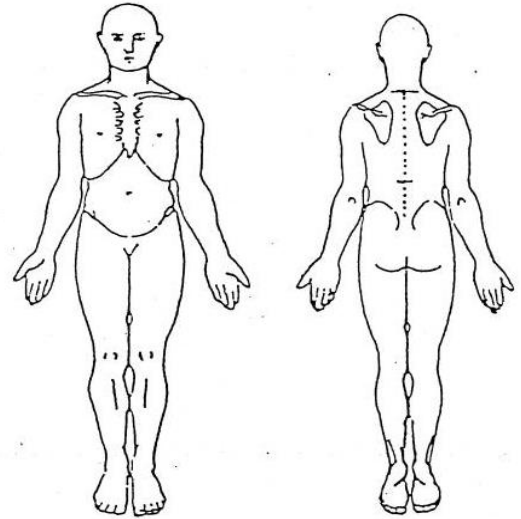
Date:										
PATIENT INFORMATION										
Last Name:			First:		Middle:		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status: Single <input type="checkbox"/> Mar <input type="checkbox"/> Other <input type="checkbox"/>	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No		If not, what is your legal name?			(Former Name):		Birth date:		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> 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 and billing statements? <input type="checkbox"/> Yes <input type="checkbox"/> 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):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance plan		<input type="checkbox"/> Location		
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Google	<input type="checkbox"/> Yelp	<input type="checkbox"/> Facebook	<input type="checkbox"/> Website	<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No										
Please indicate primary insurance			<input type="checkbox"/> Premera	<input type="checkbox"/> Aetna	<input type="checkbox"/> Cigna/Great West		<input type="checkbox"/> First Choice	<input type="checkbox"/> Regence		
<input type="checkbox"/> LifeWise	<input type="checkbox"/> Kaiser		<input type="checkbox"/> Medicare		<input type="checkbox"/> L&I	<input type="checkbox"/> Other:				
Subscriber's name:		Subscriber's S.S. no.:		Birth date:	Group no.:		Policy no.:	Co-payment: \$		
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse		<input type="checkbox"/> Child	<input type="checkbox"/> Other				
Name of secondary insurance (if applicable):			Subscriber's name:			Group no.:		Policy no.:		
Patient's relationship to subscriber:			<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> 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: <input type="checkbox"/> X-Ray <input type="checkbox"/> MRI <input type="checkbox"/> EMG <input type="checkbox"/> CT Scan <input type="checkbox"/> 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: <input type="checkbox"/> Unexpected Weight Loss / Gain <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Dizziness <input type="checkbox"/> Fatigue <input type="checkbox"/> Weakness	<input type="checkbox"/> Numbness / Tingling <input type="checkbox"/> Fainting <input type="checkbox"/> Pain at Night <input type="checkbox"/> Difficulty Swallowing / Speaking <input type="checkbox"/> Stumbling While Walking	<input type="checkbox"/> Pain with Coughing / Sneezing <input type="checkbox"/> Changes in Bowel / Bladder Habits <input type="checkbox"/> Change in Vision or Double Vision <input type="checkbox"/> Numbness / Tingling in the Saddle Area <input type="checkbox"/> Numbness / Tingling in both Hands and Feet at the Same Time
Do you have now or have you ever had any of the following? <input type="checkbox"/> Surgeries <input type="checkbox"/> Sprains / Strains <input type="checkbox"/> Fractures <input type="checkbox"/> Loss of Consciousness	<input type="checkbox"/> Pregnancy <input type="checkbox"/> Diabetes <input type="checkbox"/> Blood Pressure Problems <input type="checkbox"/> Heart Problems <input type="checkbox"/> Cancer <input type="checkbox"/> Motor Vehicle Accident	<input type="checkbox"/> Circulation Problems / Clots <input type="checkbox"/> Asthma / Breathing Problems <input type="checkbox"/> Osteoporosis / Osteopenia <input type="checkbox"/> Easy Bruising / Bleeding <input type="checkbox"/> Indigestion / Heartburn <input type="checkbox"/> Allergies / Skin Sensitivity

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

Are you currently taking any medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name and Dosage of Medication:
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Type of Pain:	<input type="checkbox"/> Sharp	<input type="checkbox"/> Burning	<input type="checkbox"/> Aching	<input type="checkbox"/> Tingling	<input type="checkbox"/> Numbness	<input type="checkbox"/> Other
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Rate your Pain (1= minimal, 10 = Severe)	Now _____ (0 to 10)	At its Worst _____ (0 to 10)	At its Best _____ (0 to 10)
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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.
- **We require a 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 WILL AUTOMATICALLY be charged \$60 for missed treatment sessions, and ALL No Shows will be charged at the full appointment price of \$120. Massage therapy is \$80 for a missed appointment.**
- Cancellation/No Show fees are not covered by insurance and must be paid before future services are rendered.

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 are responsible for any and all charges not covered by your health insurance. All balances over 30 days will be assessed a 1.5% interest charge monthly. Balances over 120 days are subject to an outside collection effort, and Advantage Sports Therapy is entitled to recover, to the extent permitted by law, collection costs, including a collection fee charged by the third party collection agency in the amount of 30% of the patients outstanding principal obligation. 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