

REGISTRATION FORM
(Please Print)

Date: _____

PATIENT INFORMATION

Last Name:		First:		<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Marital status:	
				<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	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:					Home phone: ()		
P.O. box:	City:	State:		Mobile Phone: ()			
Zip Code:	Email Address:			Work phone: ()			
May we email you information such as appointment times, exercise handouts, our newsletter or requests for information? <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.)

Please select insurance:

Premera LifeWise Kaiser Aetna Cigna First Choice Regence Medicare

L&I Fill out below MVA Fill out below Insurance ID:

Carrier Name: Claim #: Date of Injury:

Adjuster Name: Adjuster #: Notes:

IN CASE OF EMERGENCY

Name of local relative or friend: Relationship to patient: Home phone: Cell 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

REGISTRATION FORM

(Please Print)

Missed Visit Policy

At Advantage Physical Therapy, our goal is to help all patients reach a fully recovered state. Your physical therapist will provide you with your plan for care during the evaluation appointment and will inform you of the required number of visits to help you achieve your goals. Patients who attend all of their physical therapy visits are 93% more likely to fully recover from an injury whereas those that miss even one visit have a lower potential for recovery. This policy ensures that all patients have the opportunity to receive the care they need.

Please read our policy and sign at the bottom indicating you understand our expectations and our policy.

1. As experts, we know that **you will not reach full recovery if you do not attend your appointments**. To help ensure you have the best chance at recovery, we will work with you to schedule out all of your appointments after your evaluation today and in order to have the best chance at recovery, you will need to attend each visit.
2. Please note: Our goal is to begin your treatment sessions on schedule. We expect that you will **arrive on time to your appointment time**. This will allow our front office to handle their responsibilities and our specialists to provide the care you need and deserve.
3. If you're running late, we need you to call us immediately so we can prepare for your late arrival and consult with your clinician. If you are more than **10 minutes late, your session may need to be rescheduled** and if that occurs, **you will incur a \$60.00 missed visit charge**. Chronically late patients will be asked to change their appointment times. If you're late for your appointment, you're missing the time that we have specifically scheduled for your care and we cannot guarantee that we will be able to provide you with your full treatment as we have reserved the appointment time following yours for someone else.
4. Our schedule is very full and certain time slots are not always available for patients who need them. If you need to cancel or change a scheduled appointment, for any reason, **we require a day's notice during business hours, by 5:00pm the day before, so we have enough time to help someone else who needs an appointment time**.
5. There is **a \$ 60.00 fee if you do not provide at least a days' notice of your appointment change or cancellation. This is non-negotiable and it's your responsibility as insurance will not cover it.**
6. When you call to cancel an appointment, have your schedule ready as we will reschedule you right away.
7. Same-day cancellations and appointment no-shows are not permitted as they keep other patients from getting the care they need. While we understand that illness can strike at any time, we still expect that you will work to provide at least a day's notice if you cannot attend a scheduled appointment.
8. **All no shows will be charged the full appointment price of \$120.00.**
9. Patients who have multiple same-day cancellations or no-shows, will be removed from the schedule. We will also notify your physician of your non-compliance. If you're worker's comp, we are required to notify your claims adjuster if you cancel or no-show.
10. **To avoid our missed visit fee, call our office during business hours - at least ONE DAY in advance for any illness, appointment changes or cancellations.**

We look forward to working with you to meet your physical therapy goals.
Chris Tuohy, Owner

I have read this policy and by signing below I am indicating that I understand and this policy.

Patient Signature

Patient Name

Date



REGISTRATION FORM

(Please Print)

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)

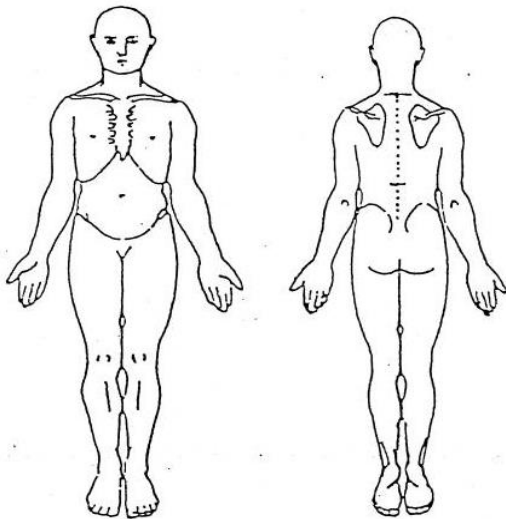
Office

REGISTRATION FORM

(Please Print)

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



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 |
|---|--|---|

REGISTRATION FORM

(Please Print)

Do you have now or have you ever had any of the following?			<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 or Type of Medication:				
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		
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?								