CONSHOHOCKEN PHYSICAL THERAPY

**REGISTRATION FORM**

**Patient's Information**

First Name:_____Middle:_____Last:_____

Street Address:_____

City:_____State:_____Zip:_____

Cell Phone:_____Home/Alternate Phone #:_____

Date of Birth:_____Social Security #:_____Marital Status: Married / Single

Email:_____

Emergency Contact:_____Emergency Contact Phone #:_____

*May we leave voice messages on the phone #'s provided? Yes / No (circle one)*

*If you circled "No" please specify the best way to contact you:*_____

***FOR MEDICARE PATIENTS ONLY:*** *Have you recently received home care for any reason? Yes / No*
*If yes, please provide:*
*Company Name:*_____*Phone:*_____ *Discharge Date:*_____

**Employment Information**

*(circle one)* Employed FT / Employed PT / Unemployed / Retired / Student

Employer / School:_____Phone:_____

Occupation:_____Supervisor's Name:_____

**Ailment Information**

Your ailment is (circle one): Work related / Auto accident / Neither

Worker's Comp or Auto Insurance Contact Person Name: _____

Contact Phone #: _____Claim #:_____Accident Date:_____

**Physician Information**

Referring Physician's Name:_____Phone #:_____

Other Physician's Names and Phone #'s to receive PT reports:_____

_____

**How did you hear about Conshohocken Physical Therapy?**

_____ I was a previous patient
_____ Physician
_____ Internet
_____ Employer
_____ Phonebook
_____ Word of mouth (Please list referring person below)
*Name:*_____
_____ Other _____

## MEDICAL HISTORY QUESTIONNAIRE

Name:_____

**Have you *ever* had:**

____Yes____No Rheumatic Fever
____Yes____No Cancer
____Yes____No High blood pressure
____Yes____No Angina or chest pain
____Yes____No Heart Attack
____Yes____No Abnormal EKG
____Yes____No Other heart trouble
____Yes____No Diabetes
____Yes____No Arthritis
____Yes____No Disease of the arteries
____Yes____No Varicose veins
____Yes____No Asthma
____Yes____No Lung disease
____Yes____No Back injury
____Yes____No Epilepsy
____Yes____No Gout
____Yes____No Surgeries
____Yes____No Osteoporosis
____Yes____No Stomach ulcers
____Yes____No Thyroid problems
____Yes____No Multiple Sclerosis
____Yes____No Stroke/Neurological Disorder

**Have you *recently* had (past 3 mos):**

____Yes____No Chest pain
____Yes____No Shortness of breath
____Yes____No Dizziness, faintness or loss of consciousness
____Yes____No Heart palpitations
____Yes____No Cough on exertion
____Yes____No Kidney problems
____Yes____No High cholesterol
____Yes____No High blood pressure
____Yes____No Breathlessness at rest
____Yes____No Coughing up blood
____Yes____No Disability of feet, ankles, knees, hips,
____Yes____No Fever/chills/sweats
____Yes____No Blood clots
____Yes____No Unusual fatigue or weakness
____Yes____No Unexplained weight loss/gain
____Yes____No Allergies
____Yes____No Depression
____Yes____No Nausea/vomiting
____Yes____No Other _____

If you checked any of the above, please explain:

_____
_____

Please check any of the following whose care you are under or have been under in the past 3 months:

____Medical or Osteopathic Doctor ____Mental Health ____Chiropractor

____Dentist ____Physical Therapist

Date of last physical examination:_____

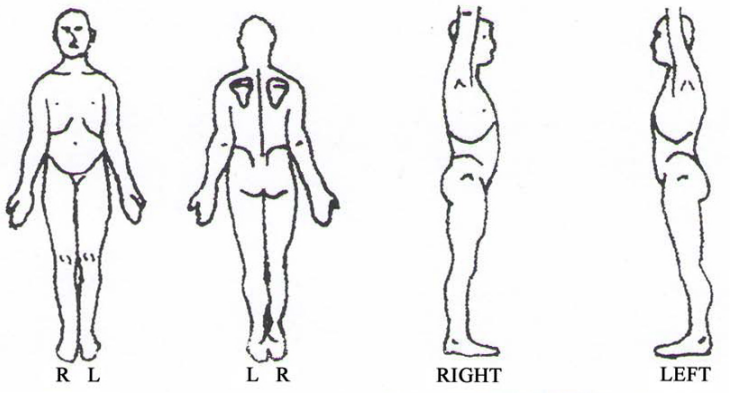
Do you smoke? Yes / No If yes, how many cigarettes/day? _____ How many years?_____

Do you drink alcohol? Yes / No If yes, how many drinks/day?_____ How many years?_____

Do you have any medical problems that would limit your ability to exercise? Yes / No

If yes, please explain:

## PATIENT HISTORY REPORT




***Where are your symptoms located? (Darken areas on the appropriate body above)***

When did your symptoms begin? _____

Circle the words that best describe your symptoms: Sharp / dull / burning / electrical / cramping / localized / radiating

Are your symptoms due to an accident or trauma?(describe)_____

What makes you feel better?_____

What makes you feel worse?_____

Please rate the following on a scale of 0-10 (0 being no pain, 10 being the worse pain you can imagine):

1. The least pain you've had in the past week: ___ out of 10
2. The most pain you've had in the past week: ___ out of 10
3. Your current level of pain: ___ out of 10

Please provide all current medications you are taking (if multiple, please provide a list for the chart):

| Medication | Dosage | Frequency |
|---|---|---|
| | | |
| | | |
| | | |

Please list any diagnostic test results (X-rays, MRI, CT Scan, Myelogram, etc.):

_____

11. Please list any interventions prior to physical therapy (injections, splints, medications, etc.)

_____

12. If 100% represents full recovery and full functioning for you, what percent are you today?

_____

## INFORMED CONSENT FORM

I consent to receiving physical therapy services which are deemed medically necessary by my referring and/or primary care physician or physical therapist. I authorize the release of medical information to my referring physicians, insurance company and/or attorneys. I hereby assign all medical benefits to be paid directly to Conshohocken Physical Therapy.

I understand that it is my responsibility to obtain a referral for physical therapy if it is required by my insurance company.

**I also understand that Conshohocken Physical Therapy requires payment of co-pays at the time of service for office visits**. I am aware the Conshohocken Physical Therapy will submit charges for services to my insurance company unless I make other arrangements. In consideration for this convenience, I am also aware that Conshohocken Physical Therapy expects payment of my balance within 30 days after receiving a statement.

**I realize I am responsible for all charges incurred, regardless of payment by my insurance company. All unpaid balances will become my responsibility within 30 days.**

In case of court award or settlement, in the hands of my attorney, I authorize and direct my attorney to pay all outstanding bills to Conshohocken Physical Therapy from the proceeds of any settlement.

If it becomes necessary for my account to be assigned to a collection agency, I agree to pay all collection costs and attorney fees. This will include legal fees at the rate of 25% of the outstanding balance.

**I understand that there is an attendance policy and may be charged a forty five dollar ($45.00) fee for "no shows" and cancellations of appointments without providing twenty-four (24) hours notice.**

Patient Signature_____Date_____

Social Security Number_____ *Parent or Legal Guardian*_____
*(If under 18 year of age)*

## PRIVACY CONSENT FORM

***Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations***

I, _____ understand that as part of my health care, Conshohocken Physical Therapy originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to receive a printed copy of the NPP
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations
- The right to receive confidential communications concerning medical conditions and treatments
- The right to amend or submit corrections to PHI
- The right to inspect and copy PHI
- The right to receive accounting of how and to whom PHI has been disclosed.

I understand that Conshohocken Physical Therapy is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Conshohocken Physical Therapy reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Conshohocken Physical Therapy change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I fully understand and accept / decline the terms of this consent.

Patient's Signature_____ Date_____

## INSURANCE INFORMATION

As a courtesy to our patients, our billing service prints claim forms for our physical therapy services and mails them to your insurance company. In order to perform this service, we must have your signed consent and insurance information (copy of your insurance card). Part of your consent allows us to forward any medical information necessary to process your claims. If you have a Workers' Compensation injury, we will also need information about the responsible party, case manager, and where to send the claims. When you arrive for your first appointment, we will verify by phone that your policy is current and what your carrier requires for approval.

**Insurance Authorization:**

Most insurance companies now require pre-approval for Physical Therapy, which we will try to help you obtain. After your first visit, the physical therapist completes an Initial Evaluation. Our office will either mail or fax a copy of your Initial Evaluation to your carrier with a request of the number of visits and estimated time frame for your therapy. Some insurers require a telephone conversation with your physical therapist as part of the approval process. Your PT will then receive approval for a certain number of visits within a specific period of time.

**Billing Insurance Companies:**

Insurance companies require that we itemize every procedure we perform. Each procedure has a numeric code (CPT code) and a specific charge according to our fee schedule. Many codes are "time dependent" and billed in 15 minute increments. Since many treatment sessions last an hour, there may be 4 different billing codes submitted for a single visit. For approved PT services, insurance reimbursement varies according to individual plans. You should refer to your "Explanation of Benefits" for details.

**Co-Payments & Deductibles:**

Most health plans require co-payments at the time of each visit. Your individual plan documents should explain your co-payment and deductible. If you do not know this information, we can help you find it out during the verification process. If you are being seen more than once per week and would like to write one check for your co-payments per week, we will accept payments in advance.

**Participating Providers:**

We try to participate with as many health plans as possible. If your carrier is not listed, please let us know so we may contact the plan.

## AQUATIC THERAPY INFORMATION

*(Only necessary if aquatic therapy is prescribed by your physical therapist)*

Aquatic Therapy is beneficial for many different reasons. Patients often feel decreased pain when in the warm water because it helps support body weight and the warmth helps to relax their muscles. Strengthening and flexibility exercises are often easier to tolerate based on this supportive environment. Balance and coordination exercises can be performed safely and easily in the pool. There are many other benefits of Aquatic Therapy that you can discuss with your Physical Therapist.

Each patient is evaluated on land prior to initiating Aquatic Therapy. Then, an individualized treatment program with a specific plan and goals is designed and implemented based upon the results of the evaluation.

The ability to swim is not required. The pool water is only 4 feet deep.

The primary goal of Aquatic Therapy is to become independent with an appropriate aquatic therapy exercise program that can be continued safely after discharge or progressed to a land-based program.

### What to bring to Aquatic Therapy

- You are required to wear pool shoes to each session. Street shoes, crocs, and flip flops are not allowed. If you do not have pool shoes we have them for sale ($12) at the front desk. You will not be allowed to walk around the pool room or enter the pool without pool shoes.
- A bathing suit is preferred but you may wear a t-shirt and shorts if needed. A changing room is provided.

It is important that you arrive at least 15 minutes prior to your appointment time in order to change into the appropriate swim attire. If not, your session may have to be shortened.

### Pool Safety Guidelines

- Always wait for a Physical Therapist before entering the pool. Never enter the pool on your own.
- Always exit the pool slowly by walking up the steps and sitting on the ledge of the pool. The warmth of the pool and the pressure from the water helps with your circulation; however, you should exit slowly to give your body time to adjust to the change in environment.
- Report any change in symptoms to your Physical Therapist, for example, an unusual increase in pain, shortness of breath, chest pain or dizziness.
- Please see list of contraindications (below) for Aquatic Therapy. You must sign that you do not have any of these contraindications prior to beginning Aquatic Therapy.

**You may NOT participate in Aquatic Therapy if you have <u>any</u> of the following:**

- Fever
- Bowel or bladder incontinence
- Open wounds, incisions, or skin lesions/infections that are oozing or bleeding
- Blistering
- Boils
- Infectious processes such as hepatitis A, strep throat, vaginal or urinary infection, staphylococcus infection or other communicable diseases
- Uncontrolled seizure disorder
- Uncontrolled cardiac problems
- Acute lung infections
- Catheters or IV lines
- Tracheotomies
- Menstruation (unless internal protection is used)
- Excessively high or low blood pressure
- Extreme fear, inappropriate or disruptive behaviors

*Also note: It is your responsibility to immediately report any changes to your health that might affect your ability to complete Aquatic Therapy. Conshohocken Physical Therapy staff reserves the right to cancel Aquatic Therapy at any time if any of the above is confirmed or suspected. Thank you for your understanding.*

Please sign below to confirm that you have read the aquatic therapy information and do not have any of the symptoms listed above:

Signature:_____ Date:_____