SPAULDING PHYSICAL THERAPY

NEW PATIENT REGISTRATION FORM

PERSONAL INFORMATION

Last Name:_____ **First Name:**_____ **DOB:**_____ **Sex:**__

Address: _____

Home Phone:_____ **Cell Phone:**_____ **Work Phone:** _____

Preferred Method of Appointment Reminders: ☐ **Phone Call** ☐ **Text**

PRIMARY INSURANCE INFORMATION

Primary Insurance Company: _____ **Policy/Claim #:**_____

Policy Holder: ☐ Self ☐ Spouse **If other,** please specify:_____

Name of Policy Holder: _____ Relationship to Patient: _____

Phone:_____ Date of Birth: _____ SS#:_____

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company: _____ **Policy/Claim #:**_____

Policy Holder: Self Spouse **If other,** please specify:_____

Name of Policy Holder: _____ Relationship to Patient: _____

Phone:_____ Date of Birth: _____ SS#:_____

EMERGENCY CONTACT

Name: _____ **Phone:**_____ **Relationship to Patient:**_____

REFERRING PHYSICIAN

Name: _____ **Phone:**_____ **Fax:**_____

Address:_____

MINOR/GUARDIAN

Is patient a minor? Yes No If yes, name of Guardian/Guarantor: _____

Relationship to Patient: _____ Phone : _____

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NEW PATIENT REGISTRATION FORM

MOTOR VEHICLE ACCIDENT

Auto Related: ☐ Yes (State:___) ☐ No
Do you have an attorney? ☐ Yes ☐ No
Do you have Med Pay? ☐ Yes ☐ No
Do you have a claim number? ☐ Yes ☐ No (If yes, please provide claim #: _____
Name of Insurance Company? _____
Name of other party's Insurance Company? _____

ATTORNEY INFORMATION

Attorney Name: _____ Phone:_____ Fax: _____

Address: _____

WORKERS' COMPENSATION

Employer	**Insurance Company**
Name of Company:_____	Patient ID/Claim #:_____
Company Contact:_____	Adjustors' Name:_____
Occupation: _____	Ins. Co. Name:_____
Address:_____	Address:_____
Phone:_____Fax:_____	Phone: _____ Fax:_____

PAYMENT AUTHORIZATION (PLEASE INITIAL)

_____ **Assignment of Insurance Benefits**
I authorize that the payment of my insurance benefits be made directly to SPAULDING PHYSICAL THERAPY for all services delivered; if I am paid directly I will promptly pay SPAULDING PHYSICAL THERAPY all monies paid to me.

_____ **Guarantee of Payment**
I understand that all payments designated at the "patient's responsibility" such as co-insurances and deductibles are due and payable at the time of service or date of receipt. I guarantee I will pay the amount deemed "my responsibility" by my insurer by the statement due date.

_____ **Certification of Information**
I certify that the information I have provided SPAULDING PHYSICAL THERAPY for payment including, but not limited to, related accidents, illnesses, or other insurers is accurate and truthful.

Signature: _____ **Date:**_____

Guardian/Legal Representative Signature: _____ **Date:**_____

SPAULDING PHYSICAL THERAPY

Patient Name: _____ DOB: _____

MEDICAL HISTORY FORM

Describe your symptoms: _____

_____

When did your symptoms start? _____

How did your symptoms begin? _____

How often do you experience your symptoms? Constantly Frequently Occasionally Intermittently

What describes the nature of your symptoms? Sharp Dull Ache Numb Shooting Burning Tingling

How are your symptoms changing? Getting Better Not Changing Getting Worse

During the past 4 weeks None Unbearable

Indicate the average intensity of your symptoms (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

How much has pain interfered with your normal work (including both work outside the home and housework)

(1) Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely

During the past 4 weeks how much of the time has your condition interfered with your social activities?

(1) All of the time (2) Most of the time (3) Some of the time (4) A little of the time (5) None of the time

In general, would you say your overall health right now is...

(1) Excellent (2) Very Good (3) Good (4) Fair (5) None of the time

Who have you seen for your symptoms? No one Chiropractor Medical Doctor Physical Therapist Other

What treatment did you receive and when? _____

What test have you had for your symptoms? (1) X-rays date: _____ (2) MRI date: _____

(3) CT Scan date: _____ (4) Other date: _____

Have you had similar symptoms in the past? Yes No

If you have received treatment in the past for the same or similar symptoms, who did you see? (1) This Office (2) Chiropractor (3) Medical Doctor (4) Physical Therapist (5) Other

What is your occupation? _____

Hand Dominance: Right Left

Do you consider this problem to be severe? Yes Yes, at times No

What aggravates your problem? _____

What does your problem prevent you from doing? _____

What alleviates your problem? _____

What type of exercise do you do? (1) Strenuous (2) Moderate (3) Light (4) None

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MEDICAL HISTORY FORM Page 2

Indicate if you have any immediate family members with any of the following:

Rheumatoid Arthritis	Diabetes	Lupus
Heart Problems	Cancer	ALS

Do you currently, or have you ever had any of the following:

Headaches	High Blood Pressure	Diabetes
Neck Pain	Heart Attack	Excessive Thirst
Upper Back Pain	Chest Pains	Frequent Urination
Mid Back Pain	Stroke	Smoking/Tobacco Use
Low Back Pain	Angina	Drug/Alcohol Dependence
Shoulder Pain	Kidney Stones	Allergies
Upper Arm Pain	Kidney Disorder	Depression
Wrist Pain	Bladder Infection	Systemic Lupus
Hand Pain	Painful Urination	Epilepsy
Hip Pain	Loss of Bladder Control	Dermatitis/Eczema
Upper Leg Pain	Prostate Problems	HIV/AIDS
Knee Pain	Abnormal Weight Gain/Loss	Visual Disturbances
Ankle Pain	Loss of Appetite	Dizziness
Jaw Pain	Abdominal Pain	Asthma
Joint Pain	Ulcer	Chronic Sinusitis
Arthritis	Hepatitis	**For Females Only**
Rheumatoid	Liver/ Gall Bladder Disorder	Birth Control Pills
Cancer	General Fatigue	Hormonal Replacement
Tumor	Muscular Incoordination	Pregnancy
Other:_____		

Height: _____ **Weight:** _____

List all prescription medications you are currently taking: _____

_____

List all over-the-counter medications you are currently taking: _____

_____

List all surgical procedures you have had: _____

_____

What activities do you do at work?

Sit:	(1) Most of the day	(2) Half of the day	(3) A little of the day
Stand:	(1) Most of the day	(2) Half of the day	(3) A little of the day
Computer work:	(1) Most of the day	(2) Half of the day	(3) A little of the day
On the phone:	(1) Most of the day	(2) Half of the day	(3) A little of the day

Injury from fall in past year? Yes No

More than one fall in past year? Yes, How many?_____ No

Anything else pertinent to your visit today? _____

_____

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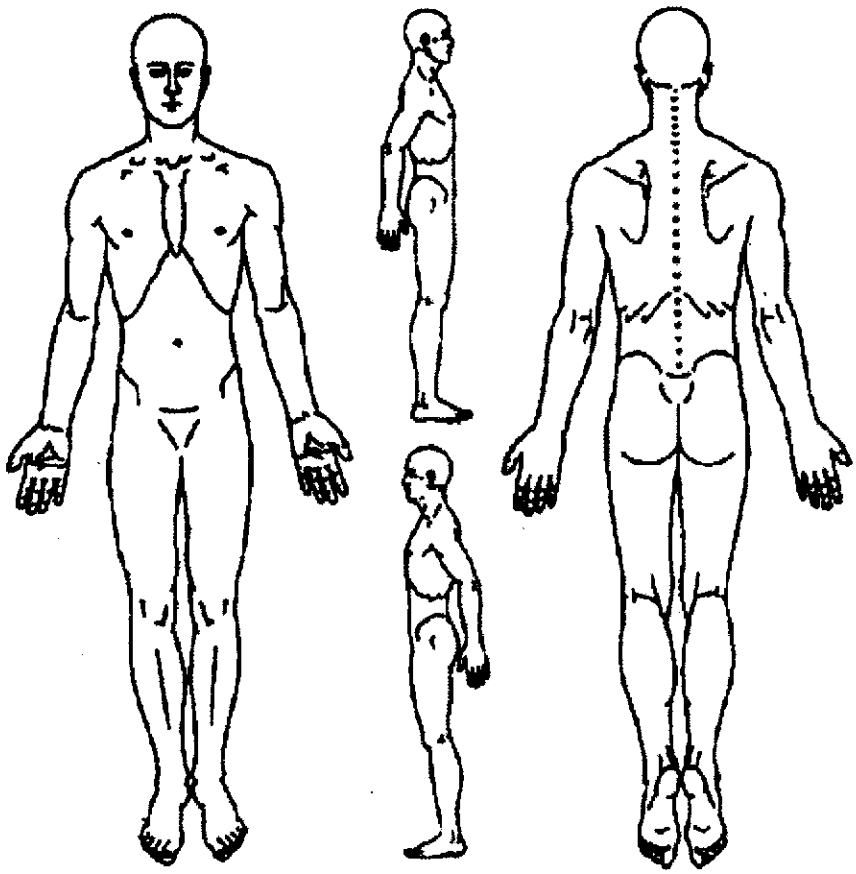
MEDICAL HISTORY FORM Page 3



On this drawing, please draw the letter abbreviations on the diagrams that most accurately reflect the type of discomfort that you are experiencing.

Numbness= N
Dull Pain= D
Burning= B
Tingling= T
Sharp Pain= P
Stiffness= S

How would you rate your pain (0-10 scale with 0= no pain and 10= max)?

Average:
Worst:
Least:

I consent to and authorize Spaulding Physical Therapy to administer all treatments and services that may be considered advisable in the judgement of my therapist and/or physician. I understand that the physical therapist may perform testing during the initial visit which may increase my symptoms, as this is a normal physiological response. I understand that certain risks, such as possible injury, may occur when participating in a physical therapy program. I hold harmless and release to Spaulding Physical Therapy of any responsibility for any injury, damages or loss of property that may occur during the use of exercise equipment and/or rehab treatments. I acknowledge my consent to receive treatment was voluntary and obtained following my initial evaluation that was performed for the determination of the appropriateness of my plan of care/treatment program. I will abide to the rules and regulations set forth by Spaulding Physical Therapy and assume all foregoing risks.

I have read and understand the above policy ad I agree to the terms of this policy.

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

SPAULDING
PHYSICAL THERAPY

PATIENT ATTENDANCE POLICY

At Spaulding Physical Therapy, we recognize the inconvenience and discomfort that results from a musculoskeletal illness or injury. Our goal is to guide patients to recovery in strength, mobility and return to everyday activity. For you to receive the maximum benefit from physical therapy, it is important for you attend your physical therapy session as scheduled. We off flexible hours to accommodate busy schedules. It is important for you to arrange your schedule so that you can be present and on time for these appointments.

Your appointment is a specific time that has been scheduled for you with the Spaulding Physical Therapy team to work on your rehabilitation goals. It is extremely important to be timely. Because we commonly have a waiting list, please let us know as soon as possible if we need to cancel or reschedule your appointment. If you are unable to attend, **YOU MUST NOTIFY THE OFFICE AT LEAST 24 HOURS IN ADVANCE to reschedule your appointment.** Failure to do so may result in a **$30 cancellation/no show fee.** Two or more unexcused absences (no show or cancellation without 24-hour notice) may result in discharge from therapy.

Failure to attend your session may hinder your recovery process. If you have multiple missed appointments, your doctor will be sent a notice. For patients who are on Workers' Compensation, we must notify your adjuster/case manager, which may affect your claim.

I have read and understand the above agreement. I understand that attendance at each therapy session is important to my recovery and will notify my therapist if I am unable to attend a session so that I may be rescheduled.

Patient/Guardian Signature: _____ Date: _____

SPAULDING PHYSICAL THERAPY

APPENDIX F
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As part of my health care, **Spaulding Physical Therapy, LLC** (The Company) creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication among The Company's personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses and surgical information to my bill.
I understand that this information is a way for third party insurance companies to assure that a service we billed for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for The Company that provides a more complete review of information uses and disclosures. I understand that I have the right to review this Notice of Privacy Practices before signing this consent.

I understand that The Company may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours of each medical office and at the central billing office.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that The Company is not required to agree to the restrictions requested. The procedure to request restriction on information use and disclosure is contained in the Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Spaulding Physical Therapy, LLC and agree to the liability limitations explained therein.

Signature of patient or legal representative	Date	Relationship to Patient

Printed name of patient
Effective date April 14, 2003
Revised date September 23, 2013