APEX PHYSICAL THERAPY

REGISTRATION FORM

(Please Print)

Today's Date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Birth Date:	E-mail:	Age :	Sex :
Street address:		Mobile phone no.:	Home phone no.:

Apt:	City:	State:	ZIP Code:
Occupation:	Employer:		Employer phone no.:

Chose clinic because/referred to clinic by (Please check one box):	☐ Dr.	☐ Insurance plan	☐ Hospital

☐ Family	☐ Friend	☐ Close to home/work	☐ Internet	☐ Other

Other family members seen here:

REFERRING PHYSICIAN NAME

Name:	E-mail address:
Street address:	Phone: / Fax:

INSURANCE INFORMATION

Primary insurance:	Insured's name:	Group no.:	Policy/Identification no.:

Patient's relationship to insured	☐ Self	☐ Spouse	☐ Child	☐ Other

Secondary insurance (if applicable):	Insured's name:	Group no.:	Policy/Identification no.:

Patient's relationship to insured	☐ Self	☐ Spouse	☐ Child	☐ Other

WORKER'S COMP/NO FAULT ONLY

Date of accident/injury:	☐ Work related injury	☐ Auto accident
Claim #:	Insurance:	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work/Mobile phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Apex Physical Therapy, P.C. or insurance company to release any information required to process my claims. All coinsurances, deductibles, and copays are expected at the time of service, no exceptions.

I hereby authorize Apex Physical Therapy to perform any physical therapy treatment and evaluation, which are deemed necessary for my health care.

Patient/Guardian signature *Date*

APEX PHYSICAL THERAPY

MEDICAL HISTORY FORM

(Please Print)

PATIENT INFORMATION		
Patient's Last name:	First:	Middle:

What is your chief complaint? _____

When did this symptom(s) begin? _____

What makes it worse? _____

What makes it better? _____

Is the pain worse in the AM or PM? _____ Does the pain radiate? _____

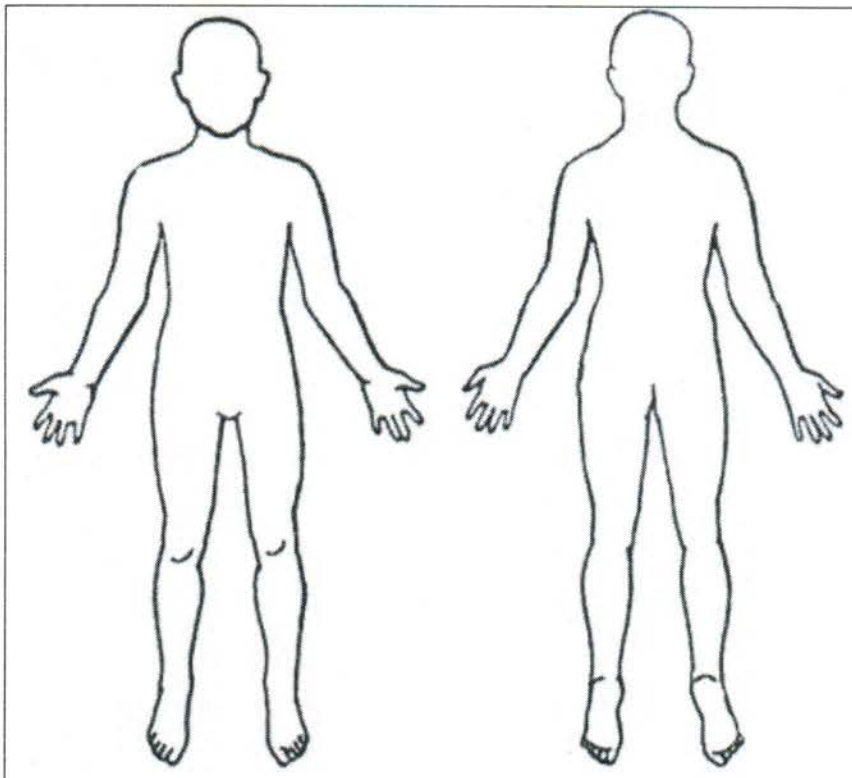
Are you currently taking any prescription or non-prescription medication? ( ) Yes ( ) No

Anti-inflammatories _____ Muscle Relaxers _____ Pain Medication _____

List Medications: _____

Have you seen another doctor for this? _____ Doctor's name _____

Have you had X-Ray or MRI done recently for this complaint? _____



Do you now have or have you ever had ANY of the following?	YES	NO
Coronary heart disease or angina		
Do you have a pacemaker?		
Epilepsy/seizures		
Cancer or chemotherapy/radiation		
Bowel or Bladder Problems		
Are you pregnant?		
Osteoporosis		
Asthma, bronchitis, or emphysema		
Diabetes		
High blood pressure		
Any pins or metal implants		
Joint replacement surgery		

Please mark the areas on the illustrations above where you're experiencing pain.

Patient/Guardian Signature: _____

APEX PHYSICAL THERAPY

PATIENT CONSENT FORM

PATIENT INFORMATION			
Patient's Last name:	First:	Middle:	Birth Date:

Benefit Assignment/Release of Information

I hereby assign all medical benefits to include major medical benefits, to which I am entitled including Medicare, private insurances, and third party payers to Apex Physical Therapy, P.C. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records to secure payment.

Consent for Treatment

I give my consent for Apex Physical Therapy, P.C. to provide me with medical care and treatment considered necessary and proper in diagnosing or treating my physical condition.

Acknowledgement of Terms & Notice of HIPPA

I understand that Apex Physical Therapy, P.C. is compliant with HIPAA will protect my Protected Health Information (PHI) and will use it as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed and full payment is received. I also authorize the release of any information pertinent to my case to any insurance, adjuster or attorney for the purpose of securing payment under this insurance policy or to any medical provider associated with my case to effectively treat me, following HIPAA guidelines. The authorization is in effect until 90 days from the date the last bill is collected. A photocopy of this Assignment shall be considered effective and valid as the original.

Payment Guarantee

I agree to pay APEX PHYSICAL THERAPY for the services provided to me or the party named above. If any law, such as workers' compensation, or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances. The Intake & Verification of Benefits Form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment for services. I understand that my good-faith payment may not be inclusive of all payments for which I am responsible and I may be billed for any remaining balance. I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of Apex Physical Therapy.

My signature indicates that I have been provided with a copy of the notice of privacy practices.
I have read and understood the above policies.

Patient or guardian signature: _____Date:_____

Witnessed by Apex Physical Therapy Staff: _____ Copy to patient ( ) Yes ( ) No