2222 South Frontage Rd, Suite D.
Vicksburg, MS 39180
Phone: (601)456-0159
Fax: (601)863-8505

Registration Form

Initial Evaluation is scheduled for ________/_______/_________at _____________with________________

PATIENT INFORMATION

First Name:______________________ **Last Name**: ____________________ **DOB**:_______/_______/__________

Address:__________________________City/State:______________________ ___________Zip:__________

SS#:___________________________ Home phone#:__________________ Cell phone#:_______________

Occupation:_____________________ Employer:______________________ Work#:______________________

Address:________________________ City/State:_________________________________ Zip:___________

Referring Physician:_________________ _________________Return to Doctor: _______/_______/__________

EMERGENCY CONTACT-

Name:________________________ **Phone#:**______________________ **Relation:**_________________

INSURANCE INFORMATION

Person Responsible for Bill: _______________ DOB:_____/_______/_________ Relation:__________________

Primary Insurance:_____________________ ID#: _______________________ Group#:__________________

Subscriber Name:______________________ DOB:_____/_______/_________ SS#:______________________

Secondary Insurance:____________________ ID#:________________________ Group#:________________

Subscriber Name:______________________ DOB:_____/_______/_________ SS#:______________________

Patient Relation to Subscriber/Subscribers:____________________________

AUTO OR WORK INJURY CLAIMS ONLY

Auto Insurance Name:____________________ ________Workers Comp. Carrier: ____________________________

Adjuster/ Claims Manager:_______________ Phone#_________________ Ext.________

Address:___________________________ City/State:____________________ Zip:_______________

Claim#:___________________________ Accident Date:_____/_______/__________

Insurance Verification- Office use only

Deductible:______________ Deductible Remaining:____________ Copay/Co-Insurance:____________

Authorized Visits Remaining:__________ **Approximate Amount for- IE:**________ **/ VISIT:**____________

Medical History

Rate your current pain between 0 and 10. Where 0 is No pain, 5 is Moderately Severe pain, and 10 is Unspeakable pain:

__________ **Body Part Injured:**______________________________

Cause of Injury: ______________________________ **Date of Injury:**_________/_______/_____________

Whose care have you been under?

- ❑ Medical Doctor (MD)
- ❑ Psychiatrist/ Psychologist
- ❑ Chiropractor
- ❑ Osteopath
- ❑ Physical/ Occupational/ Speech Therapist
- ❑ Home Health Nurse

Other:___________________

Have you ever been diagnosed with any of the following conditions (check all that apply)?

❑ Asthma	❑ Rheumatoid arthritis	❑ Diabetes	❑ Parkinson's disease
❑ Stomach ulcers	❑ Anemia	❑ Stroke	❑ Multiple sclerosis
❑ Osteoporosis	❑ Lung problems	❑ Thyroid problems	❑ Epilepsy
❑ Heart disease	❑ Chemical dependency	❑ Pacemaker inserted	❑ Tuberculosis
❑ High blood pressure	❑ Cancer(type) _____________	❑ Kidney/Liver problems	❑ Other_____________

FOR WOMEN: Are you currently pregnant or think you might be pregnant? **YES NO**

Has anyone in your immediate family ever been treated or diagnosed for any of the following (check all that apply)?

❑ Asthma	❑ Rheumatoid arthritis	❑ Diabetes	❑ Parkinson's disease
❑ Stomach ulcers	❑ Anemia	❑ Stroke	❑ Multiple sclerosis
❑ Osteoporosis	❑ Lung problems	❑ Thyroid problems	❑ Epilepsy
❑ Heart disease	❑ Chemical dependency	❑ Pacemaker inserted	❑ Tuberculosis
❑ High blood pressure	❑ Cancer(type) _____________	❑ Kidney/Liver problems	❑ Other_____________

Please list any surgeries or other injuries for which you have been treated for, including dates:

1____ **Date:**______/_______/________

2____ **Date:**______/_______/________

3____ **Date:**______/_______/________

4____ **Date:**______/_______/________

Please list any prescription medications you are currently taking (including pills, injections, and skin patches):

____

____

Which of the following over-the-counter medications have you taken in the last week (check all that apply)?

- ❑ Aspirin
- ❑ Tylenol
- ❑ Antacids
- ❑ Vitamins/Mineral Supplements
- ❑ Advil/Motrin/Ibuprofen
- ❑ Antihistamines
- ❑ Decongestants
- ❑ Laxatives
- ❑ Other______________________

ALLERGIES: ____

Are you latex sensitive? Yes No

How many caffeine containing beverages do you drink per day? ____

Do you smoke? YES NO ______ **pack/day**

Any history of illegal drug use? YES NO if yes, please list ____

How many days per week do you drink alcohol? _________

If one drink equals one beer or glass of wine, how many drinks do you have in one sitting? ___________

Have you recently noted any of the following (check all that apply)?

- ❑ Weakness/fatigue
- ❑ Weight loss/gain
- ❑ Numbness/Tingling
- ❑ Fever/chills/sweats
- ❑ Difficulty maintain balance
- ❑ Nausea/vomiting
- ❑ Dizziness/vertigo
- ❑ Shortness of breath
- ❑ Pain at night
- ❑ Headaches

Outpatient Conditions of Admission and Consent to Medical Treatment

1. **ASSIGNMENT OF INSURANCE BENEFITS / PROMISE TO PAY:** I hereby assign and authorize payment directly to **Scott Robbins Physical Therapy**. I understand that I am responsible for any charges not covered by my insurance. I understand that I am obligated to pay the account of **Scott Robbins Physical Therapy** in accordance with the regular rates and terms of the Facility. If I fail to make payments when due and the account becomes delinquent or it is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court cost, and attorney fees. I also agree that any patient or guarantor overpayments on the above Facility visit may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment.
2. **PERSONAL VALUABLES:** I understand that **Scott Robbins Physical Therapy** is not responsible for the safekeeping of money and valuables. The Facility shall not be liable for the loss or damage to any articles of personal property.
3. **NOTICE OF PRIVACY PRACTICES:** Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA) I acknowledge that I have received a copy of the Facility's Notice of Privacy Practices that provides information about how the Facility may use and disclose my protected health information.
4. **GENERAL CONSENT FOR TREATMENT AND SERVICES**: I hereby voluntarily consent for treatment by **Scott Robbins Physical Therapy**. I permit the Facility and its employees, therapists, and others involved in my care to treat me in ways they judge to be beneficial to me. I understand that I have the right to ask questions and to receive information about my care and treatment, and the right to withdrawal my consent for treatment. I agree and understand that all therapists and interns involved in my care in any way are responsible and liable for their own acts and omissions. I am aware that the practice of medicine is not an exact science and further understand that no guarantee has been or can be made as to the results of the treatments, care, or examinations in the Facility. I have been informed of the treatment procedures considered necessary for me and that the treatments/procedures will be directed by a therapist and/or intern and may be performed by such therapist and/or one or more additional therapist or employees of the Facility. I understand that one or more therapist and/or interns at the Facility may treat me or participate in my treatment. I understand that no guarantee or assurance has been made regarding **(1)** which therapist/intern will treat me or participate in my treatment and/or **(2)** the results that may be obtained from treatment.
5. **ATTENDANCE GUIDELINES:** Your therapy program is important to your health and the success of your recovery. As our patient, you will receive the best results from your therapy program by being an active participant with the guidance of your physician and therapist. You are largely responsible for the outcome of your therapy and will have better results with responsible attendance and participation. Please make every effort to keep your appointment. If you are unable to keep an appointment please call as soon as possible so that we may care for another patient. Therapy sessions are scheduled for a specific amount of time based on your needs. Please be prompt so that you may receive your full treatment. **(1)** If you are 15 minutes or more late for your appointment, your treatment session may be shortened or rescheduled to avoid interfering with others' appointments. **(2)** If you fail to attend a scheduled appointment without call or canceling, you may lose that preferred time slot. **(3)** If you have 3 consecutive no-show appointments or repeated inconsistent attendance, the referring physician will be notified and you may be discharged from therapy. **(4)** If you are sick, running fever, or have a stomach virus please call and reschedule your appointment. Ask to speak to your therapist if you have specific needs or concerns. **(5)** Remember, it is ultimately the patient's responsibility to know the requirements, benefits, limits, and co-payments of your insurance.

I certify that the above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to **Scott Robbins Physical Therapy**. I understand that I am financially responsible for any balance. I also authorize **Scott Robbins Physical Therapy** or insurance company to release any information required to process my claims. I have read and I do understand all of the outpatient conditions of admission and consent to medical treatment, I accept the terms of these conditions, and hereby consent to the treatment of my condition by a license physical therapist. He/she has fully explained to me the nature of the course of my treatment and has been a witness of my consent.

______________________________ _____/_____/_______ ____________________

Signature of the Patient/Legal Guardian **Date** **Relationship to Patient**

OFFICE USE ONLY: I do hereby certify that I have explained all the features, benefits, and complications of this treatment plan and have fully satisfied all his/her queries.

______________________________ _____/_____/_______

Signature of treating Physical Therapist **Date**