# The Green Room Physical Therapy, PLLC

Patient Registration Form

## Patient Information

| Last Name | First Name | Middle | Nickname | Married: ◯ Single: ◯ | Date of Birth |
|---|---|---|---|---|---|

| Address | Apt# | City | State | ZIP |
|---|---|---|---|---|

| Social Security # | Employer | Email |
|---|---|---|

Birth Sex (*Female, Male, or Other*): Gender Identity (*if different from birth sex*): Pronoun (*He, She, They, or Other*):

Height: feet inches Weight: lbs. Home Phone #: Cell Phone #: Work Phone #:

| Emergency Contact | Emergency Relation | Emergency Phone # |
|---|---|---|

| Referring Doctor | Referring Dr. Phone | Primary Doctor | Primary Dr. Phone |
|---|---|---|---|

## Insurance

| Primary Insurance | Member ID # | Group # |
|---|---|---|
| Policy Holder Name | Relation to Patient | Policy Holder DOB |

| Deductible ($) | Copay ($) | Coinsurance (%) | Out-of-Pocket Max ($) | Plan Annual Cap ($) |
|---|---|---|---|---|

| Secondary Insurance | Member ID # | Group # |
|---|---|---|
| Policy Holder Name | Relation to Patient | Policy Holder DOB |

| Deductible ($) | Copay ($) | Coinsurance (%) | Out-of-Pocket Max ($) | Plan Annual Cap ($) |
|---|---|---|---|---|

## Concurrent Care

| | | | | | |
|---|---|---|---|---|---|
| Have you ever had Physical Therapy before? | ◯ Yes | ◯ No | This year? | ◯ Yes | ◯ No |
| Have you ever had Speech Therapy before? | ◯ Yes | ◯ No | This year? | ◯ Yes | ◯ No |
| Have you ever had Chiropractic Care? | ◯ Yes | ◯ No | This year? | ◯ Yes | ◯ No |

Are you currently receiving Home Health Care including a Visiting Nurse or Therapist? ◯ Y ◯ N

## Current Conditions

Reason for Physical Therapy/Description of Issue:

Location of Pain:

| Date of Injury/Problem: | Is your current pain? | ◯ Intermittent | ◯ Constant |
|---|---|---|---|
| 1st Dr. Visit for Injury: | Additional symptoms? | ☐ Numbness | ☐ Tingling |

## Medical Privacy

To comply with Federal regulations regarding privacy, please answer the following.

| **May we leave messages on/with:** | | | **Also, what type of information may we leave for each:** | | | |
|---|---|---|---|---|---|---|
| Home/Cell Voicemail? | ◯ Yes | ◯ No | | ◯ Appts | ◯ Medical Info | ◯ Both |
| Work/Office Voicemail? | ◯ Yes | ◯ No | | ◯ Appts | ◯ Medical Info | ◯ Both |
| Postal Mail? | ◯ Yes | ◯ No | ☐ Newsletter | ◯ Appts | ◯ Medical Info | ◯ Both |
| Email? | ◯ Yes | ◯ No | ☐ Newsletter | ◯ Appts | ◯ Medical Info | ◯ Both |
| Another Person? | ◯ Yes | ◯ No | | ◯ Appts | ◯ Medical Info | ◯ Both |

If you answered yes to allowing us to discuss appointments and/or medical information with another person, please list the name(s) and relationship(s) below:

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## Medical History

Have you recently fallen? ◯ Yes ◯ No | If yes, when:

Please indicate if you have ever been diagnosed as having any of the following conditions.

| Condition | Y | N | Condition | Y | N | Condition | Y | N |
|---|---|---|---|---|---|---|---|---|
| AIDS/HIV | ◯ | ◯ | Heart Attack/Stroke | ◯ | ◯ | Shortness of Breath/ Chest Pain | ◯ | ◯ |
| Anemia | ◯ | ◯ | Heart Problems | ◯ | ◯ | Emotional/Psychological Problems | ◯ | ◯ |
| Arthritis | ◯ | ◯ | Hepatitis | ◯ | ◯ | Hearing or Visual Impairment | ◯ | ◯ |
| Artificial Joint(s) | ◯ | ◯ | High Cholesterol | ◯ | ◯ | Vertigo/Dizziness | ◯ | ◯ |
| Asthma | ◯ | ◯ | History of Falls | ◯ | ◯ | Do You Smoke? | ◯ | ◯ |
| Cancer, please list | ◯ | ◯ | Kidney Disease | ◯ | ◯ | Hernia | ◯ | ◯ |
| Circulatory Problems | ◯ | ◯ | Dementia | ◯ | ◯ | Severe or Frequent Headaches | ◯ | ◯ |
| Currently Pregnant? | ◯ | ◯ | Multiple Sclerosis | ◯ | ◯ | Varicose Veins | ◯ | ◯ |
| Low/High Blood | ◯ | ◯ | Obesity | ◯ | ◯ | Bowel or Bladder Problems | ◯ | ◯ |
| Depression | ◯ | ◯ | Osteoporosis | ◯ | ◯ | Infectious Diseases | ◯ | ◯ |
| Diabetes | ◯ | ◯ | Pneumonia | ◯ | ◯ | Blood Clot/Emboli | ◯ | ◯ |
| Drug/Alcohol | ◯ | ◯ | Seizures/Epilepsy | ◯ | ◯ | Gout | ◯ | ◯ |
| Have a Pacemaker | ◯ | ◯ | Thyroid Problem | ◯ | ◯ | Any Pins/Metal Implants? | ◯ | ◯ |

If any conditions are not listed, please list:

Have you ever had surgery? ◯ Yes ◯ No

If yes, please list what type and the date(s):

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Please list any allergies:

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## Medication

Are you currently taking any medications, vitamins or herbal supplements? ◯ Yes ◯ No

If Yes, Please List:

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

## Other

Please mark any of the following care that has been performed since your injury?

| | | | | | | |
|---|---|---|---|---|---|---|
| ☐ Emerg. Room Care | ☐ Neurologist | ☐ X-Rays | ☐ CT Scan | ☐ Physical Therapy | ☐ Podiatrist | ☐ Chiro |
| ☐ General Practice | ☐ Orthopedist | ☐ MRI | ☐ EMG/NCV | ☐ Occup. Therapy | ☐ Massage | ☐ Other |

What is your main goal in coming to physical therapy?

| | |
|---|---|
| Patient First Name: | |
| Patient Last Name: | |
| Patient Date of Birth: | |

# Consent for Treatment Agreement

As with all forms of medical treatment, there are benefits and risks involved with physical therapy. Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions. We encourage you to discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time before or during your treatment session. Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them. It is understood that The Green Room Physical Therapy clinic shall not be liable for loss or damage to any personal items brought to The Green Room Physical Therapy clinic during the course of treatment.

**I, the undersigned, authorize the staff at The Green Room Physical Therapy clinic to undertake such treatment and procedures as deemed appropriate to improve my condition.**

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# Attendance Agreement

The Green Room Physical Therapy strives to provide the highest quality of care while attempting to accommodate each patient's schedule. Therefore, we provide each patient a reserved time slot with a specific therapist in order to minimize wait time and assure continuity of treatment. Consistent attendance and adherence to the planned treatment regimen is paramount to your care and recovery.

While we are sensitive to the fact that an emergency may occur, tardiness and "No-shows" reduce our ability to accommodate the scheduling needs of our patients. Additionally, we often have many waitlisted patients and timely advance notice of an absence allows us to offer these patients care. As such, we request your full cooperation with the following company policy:

- If a patient is more than 30 minutes late for an appointment or does not show up for their appointment and failed to notify the practice of their tardiness without **at least a 24 hour advance notice**, a $35 no-show fee will be charged for missing the appointment. After the first "No-Show" appointment, you will receive an inquiry phone call and we will assist you in rescheduling your appointment.

- Your advance notice can be by email or phone. You may also leave a voicemail if you are notifying us after normal business hours of any necessary scheduling changes. If you cannot

provide 24 hour notice, the soonest notice you can provide is better than none and much appreciated.

- If you have two “No-Show” appointments within a one-year time period, you will receive another $35 no-show fee in the mail, along with a letter explaining why.

- If you have three “No-Show” appointments within a one-year time period, you will receive another $35 no-show fee, and we may elect to discharge you from our care and send your referring provider a note regarding your non-adherence to your therapy plan of care. **You will be notified by letter if dismissal was deemed necessary.**

- Patients are responsible for all no-show fees, not insurance companies or third party payers. Also, all no-show fees must be paid prior to a patient’s next visit.

By signing below, I acknowledge that I have read the aforementioned company attendance policy and agree to its terms.

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# Financial Agreement

You are encouraged to contact your insurance provider for verification and clarification of allowed benefits. IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE BENEFITS AND TO KNOW WHICH PROVIDERS AND NETWORKS ARE COVERED BY YOUR INSURANCE COMPANY. Some insurance plans have limits, either monetary or numerical, as to how many outpatient physical therapy visits they will cover. It is important to understand your individual plan. As a courtesy to you, we will try to provide you with the most up-to-date information about your benefits, but ultimately, you are expected to know your co-pay and deductible amounts and benefits.

Your insurance policy is a contract between you and your insurance carrier – we are not a party to that contract. As a courtesy to you, The Green Room Physical Therapy will submit claims to your insurance carrier in a timely manner. In order to facilitate claims processing, you MUST provide The Green Room Physical Therapy all insurance policy information and any changes to your insurance. In most instances, we will accept payment directly from your insurance company in accordance with your policy’s terms and apply the payment to your account. Contractual discounts will be applied at that time.

If The Green Room Physical Therapy will be billing a worker’s compensation carrier, it is imperative that we receive your claim information as quickly as possible. We also require your personal insurance information in the event that your worker’s compensation claim is denied.

If you do not have insurance coverage, you will be expected to pay your bill, in full, at the time of service or make appropriate payment arrangements. For your convenience, we accept cash, checks, major credit cards, and debit cards. The Green Room Physical Therapy will not bill any insurance plan at a later date if the patient/legal guardian elects to be Self Pay at the time of service.

**TERMS OF AGREEMENT**

I, the undersigned, hereby agree with the following:

- All co-payments must be paid at the time of service. This arrangement is part of my contract with my insurance company. Failure on the part of The Green Room Physical Therapy to

collect co-payments from patients may be considered fraudulent. I agree to pay my co-payment at each visit.

- I am aware that some, and perhaps all, of the services/supplies I have received may be non-covered, denied by my insurance company, or not considered reasonable or necessary by my insurance company. I understand that I am financially responsible for all charges not paid by my insurance company.

- I will present a copy of a current, valid insurance card to provide proof of my existing insurance coverage. I will notify The Green Room Physical Therapy of any change in my information, including but not limited to, address, phone number, and insurance coverage.

- My insurance company may need me to supply certain information directly. It is my responsibility to comply with all requests. I am aware that insurance coverage does not guarantee payment of services.

- I understand that I am financially responsible for all charges not paid by my insurance company. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of my signature below on all insurance claims.

- I understand, that despite any possible pending settlement, such payment for services is not contingent on any settlement, judgment, or verdict by which I may eventually recover.

- I understand that I may be assessed a charge of $35 for untimely appointment cancellations and no-show appointments. These charges are my responsibility and not covered by my insurance.

- I understand that I will be charged a $25 fee for issuance of a non-sufficient funds check. This charge is my responsibility and not covered by my insurance.

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# HIPAA/Notice of Privacy Practices

The Green Room Physical Therapy is dedicated to keeping all of your health information confidential. We keep our records in order to provide you with quality care. We use your health information only:

- For treatment purposes, billing purposes, operation of the practice, as required by law, to avert a serious threat to health or safety, to send to military and law enforcement departments (as required by law), and to send to worker's compensation programs.

Your rights regarding the health information we maintain about you include (by written request):

- Inspect your health information used to make decisions about your care.
- Amend information that you feel is incorrect.
- Request a restriction or limitation on health information that we disclose.
- Obtain a list of accounting of any disclosures of your information not listed above.

Please ask the office staff if you have further questions regarding your privacy. A more detailed HIPAA is available in our clinic upon request or anytime on our website.

I have read the above abbreviated version of the HIPAA privacy act and have been advised that I may have a copy of the full version to keep.

## Consent to Treat a Minor

| (Only complete this section if Patient is a Minor) | |
|---|---|
| Approving Parent/Legal Guardian/Authorized Representative Full Name: | |
| Approving Parent/Legal Guardian/Authorized Representative Relationship to the Patient (Minor): | |

The undersigned does hereby authorize The Green Room Physical Therapy consent to exam and treat the above mentioned minor by employees of The Green Room Physical Therapy without a Parent, Legal Guardian, or Authorized Representative present.

**I have read and understand the above Consent for Treatment Agreement, Attendance Agreement, Financial Agreement, HIPAA Notice, and Consent to Treat a Minor Agreement and agree to all terms above.**

| | |
|---|---|
| **Patient or Patient's Guardian Signature** | **Current Date** |