# Patient Registration

(Please complete all pages. Thank you.)

## PATIENT INFORMATION

| | | | |
|---|---|---|---|
| PATIENT NAME (Last, First, Middle Initial) | | EMAIL ADDRESS | |
| ADDRESS | | SOCIAL SECURITY NUMBER | DATE OF BIRTH |
| CITY STATE ZIP | | | |
| HOME TELEPHONE NUMBER | CELL TELEPHONE NUMBER | WORK PHONE NUMBER | MALE FEMALE (circle one) |
| FAMILY PHYSICIAN | MARTIAL STATUS | OCCUPATION/EMPLOYER | |

Would you like to join our email list to receive news, updates and specials? Yes/No

**How did you hear about us? Check one** Doctor Advertisement
Friend/Relative (who?)_____ Other_____

## WHO IS FINANCIALLY RESPONSIBLE FOR TREATMENT?

__Myself __ My Spouse __My Parent(s)

## INSURANCE INFORMATION

| | |
|---|---|
| Primary Insurance Company: | Secondary Insurance Company: |

Please give your insurance card/cards to the receptionist so they can make a copy for your record.

## POLICY HOLDER'S INFORMATION (If **NOT** the patient)

| | | |
|---|---|---|
| NAME | RELATIONSHIP TO PATIENT | EMPLOYER |
| ADDRESS (if different from above) | | DATE OF BIRTH |
| CITY STATE ZIP | | HOME TELEPHONE (if different from above) |

## EMERGENCY CONTACT

| | |
|---|---|
| NAME (Last, First, Middle Initial) | RELATIONSHIP TO PATIENT |
| ADDRESS CITY STATE ZIP | TELEPHONE # |

# Patient History

*The answers to the following questions are needed by your therapist to develop the best plan of care for you and will be held in strict confidence.*

1. For what reason are you seeking physical therapy services? _____
   **Please rate your pain (from 0-10/10) for the current time _____, at worst _____, and at its best _____.**
2. Have you seen someone (physician/chiropractor) for this problem recently? Yes No
   If yes, name of provider and date seen? _____
3. Have you received Physical Therapy, Occupational Therapy, or Speech Therapy during the previous year? __ Yes __ No If yes, when/how many? _____
4. Is this visit because of an injury? __ Yes __No

   a. **If yes**, have you ever been injured or suffered previous pains/problems in the area(s) before this injury? __Yes __No If yes, when? _____
   b. Have you had a recent X-ray, CT, or MRI of injured area? __ Yes __No
      When _____ Where _____
   c. Did you recover from this injury? __ Yes __No

5. **Female patient:** Are you pregnant __Yes __ No ___Maybe

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6. From the list below, please check those activities that you are either unable to perform in a normal fashion or have difficulty performing because of your pain/problem.

| | Difficult | Unable | | Difficult | Unable |
|---|---|---|---|---|---|
| Sit | [ ] | [ ] | Housework | [ ] | [ ] |
| Stand | [ ] | [ ] | Yard work | [ ] | [ ] |
| Walk | [ ] | [ ] | Twist | [ ] | [ ] |
| Push | [ ] | [ ] | Bend | [ ] | [ ] |
| Pull | [ ] | [ ] | Squat | [ ] | [ ] |
| Lift | [ ] | [ ] | Drive | [ ] | [ ] |
| Stretch | [ ] | [ ] | Ride in car | [ ] | [ ] |
| Climb | [ ] | [ ] | Other _____ | [ ] | [ ] |
| | | | Other_____ | [ ] | [ ] |

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7. Please list below any medication/supplement/vitamins taken on a regular basis (please include dosage).

_____ _____ _____ _____
_____ _____ _____ _____

8. Are you allergic to any medications? Yes No
   If yes, please list: _____

9. Please list all prior surgeries:
_____
_____

10. Do you have any metal implants or pins? Yes No

11. Have you had unexplained weight gain or weight loss in the past month? Yes No

**a. Current height and weight: _____**

12. Do you have or have you had any of the following?

| | Now | Past | | Now | Past |
|---|---|---|---|---|---|
| Dizziness/ Vertigo | | | Diabetes | | |
| Stroke | | | Arthritis | | |
| Severe headaches | | | Osteoporosis | | |
| Blurred Vision | | | | | |
| Double Vision | | | High blood pressure | | |
| Ringing in your ears | | | Shortness of breath | | |
| Nausea | | | Asthma | | |
| Epilepsy | | | Chronic Bronchitis | | |
| Multiple Sclerosis | | | | | |
| | | | Irregular heartbeat | | |
| | | | Chest Pain | | |
| Depression | | | Heart disease | | |
| Chemical Dependency | | | Heart Attack | | |
| Fever | | | Pacemaker | | |
| Confusion | | | Congestive Heart Failure | | |
| Pain in Calves | | | Peripheral Vascular Disease | | |
| Muscle Pain | | | Thrombophlebitis | | |
| Fatigue | | | Anemia | | |
| Skin Disorder | | | Hemophilia | | |
| | | | | | |
| Smoker<br>How many Packs a day?_____ | | | Cancer<br>Please list type _____ | | |
| | | | Thyroid problems | | |
| Tuberculosis | | | Kidney/ Bladder Problems | | |
| Hepatitis C | | | Liver Problems | | |
| Acquired Immune Deficiency/ HIV | | | Abdominal pain/discomfort | | |
| Hepatitis B | | | Ulcer/ Colitis | | |
| | | | Hernia | | |

If your family has a history of any of the above please list:

_____

List any other information regarding your medical history not detailed above:

_____

13. Have you fallen in the past 2 years? If so, how many times and approximately when did the fall(s) occur?

_____

Pain Disability Index

Pain Disability Index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.

For each of the 7 categories of life activities listed below, please circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

**Family/Home Responsibilities:** This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g. house work) and errands or favors for other family members (e.g. driving the children to school)

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

**Recreation:** This disability includes hobbies, sports, and other similar leisure time activities.

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

**Social Activity:** The category refers to activities, which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

**Occupation:** This category refers to activities that are part of or directly related to one's job. This includes non-paying jobs as well, such as that of a housewife or volunteer.

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

**Sexual Behavior**: This category refers to the frequency and quality of one's sex life.
No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

**Self Care:** This category includes activities, which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed, etc.)

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

**Life-Support Activities:** This category refers to basic life supporting behaviors such as eating, sleeping, and breathing

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability


## *ABove* Physical Therapy Policies

The policies of *ABove* Physical Therapy, LLC (*ABove* PT) are part of our agreement with you pertaining to your use of the *ABove* PT facility and equipment and your participation in any *ABove* PT activities or programs. Any change in these policies is at the owner's discretion and can occur at such time *ABove* PT sees fit. Failure to abide by these policies may result in loss of your privileges to use the facility or equipment or to participate in activities or programs and may result in loss of fees already paid. *ABove* PT enforces these policies using its discretion.

**By Appointment Only** All sessions are by appointment only. Appointments are made on a first come, first serve basis.

**Early Arrival for Sessions** It is important that clients arrive at least 5 minutes early for sessions. This will allow you to relax and prepare for your session. Our appointments are scheduled on the hour and arriving 5 minutes early helps to insure that you get a full session.

**Hours of Operation** *ABove* PT's hours of operation are by appointment only from Monday through Friday, with the exception of holidays and inclement weather. *ABove* PT may change its hours of operation as it determines necessary.

**Safe Use of Equipment** All equipment must be used in accordance with your instructor's instructions. At no time will a client be allowed to use the equipment at *ABove* PT without supervision. FAILURE TO USE EQUIPMENT AS INSTRUCTED MAY RESULT IN INJURY TO YOURSELF OR OTHERS.

**Return Check Fee** You will be charged $25 for any check s returned due to insufficient funds.

**Return of Products** All fitness products, rehabilitation products and other *ABove* PT products are non-exchangeable or non-refundable

**Use of Cell Phones, & Pagers** To be courteous of other clients, please have your cell phone & pagers in the silent or off position.

**Dress Code** Please dress comfortably for your sessions keeping in mind that *ABove* PT wishes to maintain an environment where all individuals will feel comfortable exercising and receiving therapy. If you have any questions regarding the appropriateness of attire, please do not hesitate to ask your *ABove* PT personnel.

**Personal Belongings & Theft** *ABove* PT provides shelves and racks for hanging and storing your belongings. Although *ABove* PT tries to maintain a safe environment, theft can occur anywhere. *ABove* PT is not responsible for any theft or your personal belongings. *ABove* PT recommends that you leave valuable belongings at home or locked in your car. *ABove* PT is not responsible for any theft in its facility, in the parking lot or surroundings.

**Refusal of Service** *ABove* PT may refuse services to anyone at anytime. If services are refused after a purchase is made, a full-prorated refund will be made upon such refusal of services (unless the refusal is due to a breach of your agreement or these policies).

**Semi-private Sessions** When you volunteer to be a partner with another *ABove* PT customer, we ask that you observe the following protocol in order to enhance the experience for you and your exercise partner:

- **Please be on time for your session** Emergencies happen, and traffic happens. But, if at all possible, please call *ABove* PT and your partner if you will be late. Your instructor prepares the session for both of you and if one party is repeatedly late, it disrupts the flow of the session.

- **If you must miss a session, let your partner know in advance** In the event of a no show by a partner, that partner must still pay for the session unless timely cancellation notice is received.

- **Private session in the event of cancellation** If one partner cancels a session in advance, the other partner may elect to have a private session for the scheduled period at the private session rate. **Cancellation Fee** In today's hectic world unplanned issues come up for all of us. We recognize this fact, but we respectfully request that you cancel your scheduled appointment by phone or e-mail 24 hours in advance. This will allow us the opportunity to offer that appointment to another patient Cancellations must be received 24 hours prior to your scheduled session to avoid being charged for the session. This fee is not covered by insurance carriers and will be your responsibility to pay at the time of your next visit. Our aim here is to open otherwise unused appointments for our patients, not to collect missed appointment fees. Your cooperation and consideration are appreciated, as we will be strictly enforcing this policy.

## Informed Consent For Physical Therapy Services

Do not sign this form with out reading and understanding its contents.

Physical therapy involves many different types of evaluation and treatment. At ABove Physical Therapy, LLC (ABove PT ) we use a variety of procedures and modalities to address your issues and assist you in improving your function. As with all forms of medical treatment there are benefits and risks involved with receiving physical therapy.

I acknowledge that my attendance or use of the ABove Physical Therap, LLC (ABove PT) facility and equipment or participation in any ABove PT activities or programs could cause injury to me. As a pre-condition to allowing me to use the facility or equipment and participate in any physical therapy activities or programs, I accept the risks associated with receiving physical therapy services at ABove PT or with the ABove PT equipment ("Risks"), including but not limited to the following: worsening of any medical condition or injury I might have, personal injury, theft, or contagion. I represent and warrant that my physician has prescribed the physical therapy services to be received by me, and that I have consulted with my physician about the appropriateness and safety of the physical therapy services offered at ABove PT and on the ABove PT equipment prior to receiving such services. I represent and warrant that I will not use the ABove PT facility or equipment or participate in physical therapy services at ABove PT if I possess a condition or injury that makes such use or participation inadvisable. I agree not to participate in any activities that are beyond my physical capacity.

I acknowledge and understand that, during the course of my therapy and treatment, it is likely that various types of physical therapy procedures ("Procedures") may be utilized, which are considered necessary techniques for the ordinary care and treatment of my condition(s) by my physician and/or physical therapist. While these Procedures may be routinely performed by physical therapists without incident, there are certain risks associated with each of these Procedures.

My physical therapist and physician are responsible for providing me with information about the Procedures and for answering all of my questions regarding the Procedures. It is not possible to enumerate each and every risk for every Procedure utilized in physical therapy. However, the physical therapist (in addition to my physician) providing me services at ABove PT has attempted to identify the most common Procedures, their risks and possible alternatives. If I have further questions or concerns regarding the Procedures, I agree to ask my physical therapist and physician to provide additional information.

The Procedures referenced herein may include, but are not limited to, the following: ultrasound, electrical stimulation, hot packs, cold packs, ice massage, soft tissue massage, Jones strain-counterstrain, joint and tissue mobilizations, craniosacral therapy, visceral manipulation, lymphatic drainage, iontophoresis, manual traction, mechanical traction, stretching and strengthening therapeutic exercises (including, but not limited to pilates, gyrotonic exercise, treadmill, elliptical, upper body ergometer, bike, Precore total gym and other exercises.

I consent to and authorize the physical therapists at ABove PT to utilize the Procedures, such as those set forth above, as they may deem reasonably necessary or appropriate in providing me physical therapy services as they see fit in their professional judgment, including those Procedures that may be unforeseen or not known to be needed at the time this consent is obtained. This consent shall also extend to treatment of all conditions which arise during the course of such Procedures including those conditions which may be

unknown or unforeseen at the time this consent is obtained.

By signing this form, I acknowledge and understand that I have been informed in general terms of the following;

- (a) The nature and purpose of the Procedure(s);
- (b) The material risks of the Procedures(s); and
- (c) The practical alternatives to such Procedure(s).

If I have further questions or concerns regarding these Procedures, I agree to ask my physical therapist and physician to provide additional information.

I understand that ABove PT concerning the outcome and/or result of any Procedure(s) has made no guarantees or assurances to me.

I understand that the physical therapists providing my therapy will rely upon my documented medical history, as well as other information obtained from me (including this informed consent), my family or other having knowledge regarding me, in determining whether to perform the Procedure(s) or the course of treatment for my condition or injury and in recommending the Procedure. I acknowledge and warrant that the information that I have given regarding my medical history and current condition is accurate to the best of my knowledge.

# Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances, which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice if effective as of September 23, 2013and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that our office has violated your protections. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Maria-Elena Bove for any additional questions you may have regarding you privacy rights. mariaelenabovept@gmail.com or 770-904-2332.

**Above Physical Therapy Policies**

I have read and received a copy of the facility policies. I understand that failure to abide by these policies my result in loss of my privilege to use the facility or the equipment or participate in activities or programs and may result in loss of fees already paid.

_____ Initials

**Privacy Policy**

I have been offered a Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act of 1996.

_____ Initials

**Informed Consent**

I acknowledge and understand that I have been informed in general terms of the following:

a) The nature and purpose of the procedure(s);
b) The material risks of the procedure(s); and
c) The practical alternatives to such procedure(s).

_____ Initials

**Missed Appointment Policy**

Your appointment time has been reserved especially for you.

- As a courtesy, we will attempt to leave you a reminder through an automated service.
- Please call 24 hours in advance to cancel or reschedule your appointment.
- A credit card number will be necessary to hold your appointment time if you have repeatedly missed appointments without notice. **A $50.00 fee will be charged for appointments missed or canceled without 24-hour notice.**

_____ Initials

**I certify that the information I have provided is complete and true to the best of my knowledge.**

Signature_____ Print Name_____

Date: _____

## Financial Policy

**Insurance**
We are in network with various insurance companies and will gladly call to find out general benefits for our clients. However, we strongly recommend contacting your insurance company if you have questions regarding your coverage prior to your visit.

**Co-Payments and Co-Insurance**
All co-payments must be paid at the time of service. Some plans require only your co-payment amount for office visits, but you may have an additional financial responsibility after services are rendered in the form of a deductible or co-insurance percentage. Please contact your insurance company for more specific details.

**Missed Appointments**
Our policy is to charge for missed appointments or for appointments not cancelled prior to 24 hour notice. **There is a $50.00 late cancellation fee**.

**Returned Check Fee**
There is a $15.00 fee for checks returned by the bank for non-sufficient funds.

***Your signature below signifies that you understand our financial policies and the physical therapy benefits of your insurance plan. Your signature also signifies you will be solely responsible for any charges incurred in this office that your insurance plan may not cover.**

Signature_____ Print Name_____ Date_____

OR

Signature_____ Print Name_____ Date_____
(Parent/Legal Guardian if Patient is a Minor)