Patient Registration Form

Today's Date: _____________

Name: ____ Date of Birth: __________________

Gender (circle): M F Marital Status: ______________ SS#_________________________

Street Address:____

City/State/Zip: ____

Home Phone: ______________ Cell Phone: _____________ Email: ______________________

*_**Referring Provider**_ (or Primary Care Physician if applicable): ____________________________

____

Emergency Contact: ____

Phone: ____________________________Relationship to Patient: ________________________

____

Employer: ____ Occupation: ________________

Address: _______________________________________ Supervisor/Contact:______________

City/State/Zip: ___________________________________ Phone: ______________________

____

***How did you hear about Churchill Orthopedic Rehab (Check all that apply):**
Referring Physician: __ Friend: __ Family: __ Website: __ Other: ________________

____

- I consent to treatment necessary for the care of the above patient.
- I authorize release of all medical records, copies of this authorization and any information necessary for my treatment or claim to my health care providers and their billing agents as needed.
- I have read and fully understand the above consent for treatment, release of medical information, insurance authorization and my financial responsibility.

Patient Signature: ____ Date: ________________

Updated January 2018

Injury / Symptom Information

Name: ______________________

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What are you currently seeking Physical Therapy treatment for?

When did you get injured or when did your symptoms begin?

How did you get injured?

Have you had imaging for this injury (circle): X-ray MRI CT scan Ultrasound Other:

What other treatment have you received for this injury?

Have you had these symptoms or this injury before? YES NO
If so, how did you manage them?

Are your symptoms getting (circle one): Better / Worse / Same

On a scale from 0 (NO pain) to 10 (WORST imaginable), how would you CURRENTLY rate your pain?
0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

How would you describe your pain (sharp, dull, shooting, burning, aching, throbbing, tingling, numb, heavy, other: __________ (circle all that apply)

What are your goals or expectations for physical therapy?

____

____

____

Please list what activities your injury is interfering with:

1.

2.

3.

Medical History
Name: ____________________________

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

- ☐ Unexplained weight loss/gain
- ☐ Changes in bowel or bladder function
- ☐ Weakness/fatigue/loss of energy
- ☐ Changes to menstrual cycle
- ☐ Dizziness/lightheadedness
- ☐ Difficulty maintaining balance
- ☐ Unexplained falls
- ☐ Fever/chills/sweats
- ☐ Nausea/vomiting
- ☐ Change in appetite
- ☐ Difficulty swallowing
- ☐ Pain at night
- ☐ Infection (UTI, wound, etc.)
- ☐ Headaches/Migraines
- ☐ Shortness of breath
- ☐ A change in your health
- ☐ Numbness/Tingling
  where?

Have you ever been diagnosed or undergone treatment for any of the following (check all that apply)?

- ☐ Cancer
  Type:______________ When:__________
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Angina / Chest Pain
- ☐ Stroke / Peripheral Artery Disease / Neuropathy (circle all that apply)
- ☐ Blood Clot
- ☐ Anemia
- ☐ Diabetes
- ☐ Osteoporosis / Osteopenia (circle one)
- ☐ Rheumatoid arthritis
- ☐ Osteoarthritis
- ☐ Thyroid problems
- ☐ Chemical dependency
- ☐ Eating Disorder
- ☐ Neurological Disorder (type: ______________________)
- ☐ Lung Condition/Disease (type: ______________________)
- ☐ Immunosuppression or compromised
- ☐ Other: __________________

Please list ALL current medications (not just for this injury):

1.
2.
3.
4.

Please list any surgeries, major injuries, or other conditions requiring hospitalization (include date):

1.
2.
3.
4.

Are you allergic to any of the following (check all that apply)?

- ☐ Sulfa Drugs
- ☐ Latex
- ☐ Metal
- ☐ Adhesive (i.e. bandaid, athletic tape, etc.)
- ☐ Hard work ☺
- ☐ Other: ____

In the past month have you been bothered by having little interest or pleasure in doing things? YES NO

Are you pregnant?	Yes	No	Maybe
Do you have a pacemaker?	Yes	No	
Do you live alone?	Yes	No	
Do you have stairs in your home?	Yes	No	
Do you smoke?	Yes	No	

What is your occupation:

Signature: ____ Date: ____________________

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"Patient Appointment Policy"

We understand that there are times our patients must cancel an appointment. Our practice model is to only schedule one (1) patient per half hour. This enables our physical therapist(s) to spend quality time with the scheduled individual, in working towards your recovery. Recently, we have experienced an increase in patients not keeping scheduled appointments, not calling to cancel in a timely manner or calling at the time of the scheduled appointment to cancel, when the therapist, space and materials have already been prepared and are ready for you. Without timely notice of cancellation we are unable to offer another patient a time slot that may have worked better for them or wait listed for that time. In addition, after three (3) missed appointments in a one (1) month period, the patient's scheduled appointments will be removed and they will need to call on the day they want to come and accept an available time. Emergency or extenuating circumstances will be considered.

Thank you for being a valued patient and for your understanding with regards to this policy.

Patient Agreement

Please read the following carefully and discuss any concerns with a Churchill Orthopedic Rehabilitation representative.

I, ____
(patient or legal guardian)

Patient/Legal Guardian Agree:

1) To pay agreed upon fee(s) at the time of service;
2) To provide a copy of my driver's license, insurance cards and credit card for payment purposes;
3) To bring in or forward all payments received from insurance provider(s) or other payers for treatment to Churchill Orthopedic Rehabilitation within two (2) weeks of receipt of said payment. If said payment is made payable to me, I agree to endorse payment intended for Churchill Orthopedic Rehabilitation to them (i.e. "For deposit to Churchill Orthopedic Rehabilitation and sign my name";
4) To sign Churchill Orthopedic Rehabilitation authorization(s) to debit or charge my debit/credit card for office fees and/or services incurred by me and paid by insurance to subscriber (me), etc. not to Churchill Orthopedic Rehabilitation as described in #3 herein or on request;

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5) I further agree to pay a **$ 75.00 "No-Show Appointment fee"** to be applied to my credit or debit card. "No Show" means failure to attend a scheduled appointment;
6) The $75.00 "No Show" fee will also be due and owed for appointments not cancelled at least 24 hours in advance of the scheduled appointment;
7) Medicare patients accept responsibility for Medicare Deductible and/or Coinsurance not covered by insurance upon receipt of invoice; and
8) If an outstanding balance of which you were notified is not paid within 6 months will be responsible for the outstanding balance and all costs associated with collection, which includes collection agency fees, court costs and reasonable legal fees.

My signature verifies that I read, understand and agree to **ALL** of the statements above and accept the listed terms and conditions.

Signature: ___________________________________ Date: _______________
(Patient/Legal Guardian)

Print Name: ____

Relationship to the Patient_______________________ Date: _______________

Churchill Orthopedic Rehabilitation
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Written Acknowledgement/Family and Friends Disclosure Form

Our Notice of Privacy Practices provides information about how we may use and disclose PHI about you. **We may leave PHI, Protected Health Information, on an answering machine that is attached to the phone number you have given us, in an e-mail directed to your e-mail address, in a letter addressed to you, or in other forms of personal communications, unless you object to this.** As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.
I, ______________________________ (Please print patient name) have received a copy of the Medical Practice's Notice of Privacy Practices, for review and/or I have been given a copy if one was requested.
I understand that I may ask COR questions if I do not understand any information contained in the Notice of Privacy Practices.

You may disclose health information, PHI, to the following:
Either **in person** or **by phone**:

Spouse Name
______________________________ # ______________________
Parent(s) Name(s)
______________________________ # ______________________
Sibling(s) Name(s)
______________________________ # ______________________
Other:
Relationship ______________
Name ______________________ # ______________________
Relationship ______________
Name ______________________ # ______________________
Relationship ______________
Name ______________________ # ______________________

______________________ ______________________
Patient Signature Date

______________________ ______________________
Authorized Representative of Patient Date

____
Relationship to Patient
Disclose no PHI, emergency situations only contact:
Name______________________________
Relationship______________________________ # ______________________