

## **Patient Registration Form**

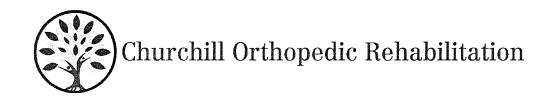
| Today's Date:  |   |  |  |
|--|---|--|--|
| Name:  | Date of Birth:  |  |  |
| Gender (circle): M F Marital St  | tatus: SS#  |  |  |
| Street Address:  |   |  |  |
|  |   |  |  |
| Home Phone: Cell   | Phone: Email:   |  |  |
| *Referring Provider (or Primary Care   | Physician if applicable):   |  |  |
| Emergency Contact:   |   |  |  |
| Phone:Relationship to Patient:   |   |  |  |
| Employer:  | Occupation:   |  |  |
| Address:   | Supervisor/Contact:   |  |  |
| City/State/Zip:  | Phone:  |  |  |
|  | Orthopedic Rehab (Check all that apply):  Family: Website: Other:   |  |  |
| <ul> <li>I authorize release of all medi<br/>information necessary for my<br/>billing agents as needed.</li> <li>I have read and fully understa</li> </ul> | sary for the care of the above patient. ical records, copies of this authorization and any treatment or claim to my health care providers and their and the above consent for treatment, release of medical rization and my financial responsibility. |  |  |
| Patient Signature:   | Date:   |  |  |

| Injury / Symptom Information Name:   | Churchill Orthopedic Rehabilitation       |
|--|---|
| 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 If so, how did you manage them?             | NO  |
| Are your symptoms getting (circle one): Better / Worse   | / Same                                    |
| On a scale from o (NO pain) to 10 (WORST imaginable), h $0-1-2-3-4-5-6-7$                          |   |
| How would you describe your pain (sharp, dull, shooting, but heavy, other: (circle all that apply) | rning, aching, throbbing, tingling, numb, |
| What are your goals or expectations for physical therapy?  |   |
|  |   |
| Please list what activities your injury is interfering with:                                       |   |
| 2.   |   |
| 3-   |   |

|  | cal History<br>e:                       |             |           |          |                      | hurchill  | l Orthopedic Rehabilitation  |
|--|---|-------------|-----------|----------|----------------------|-----------|------------------------------|
|  | Have you <i>RE</i> 0                    | CENTLY r    | noted an  | y of t   | the following (chec  | k all tha | at apply)?                   |
|  | • |             |           |          | explained falls      |           | Infection (UTI, wound, etc.) |
|  |   |             |           |          | er/chills/sweats     |           | Headaches/Migraines          |
|  |   | ergy        |           |          | usea/vomiting        |           | Shortness of breath          |
|  | ,                                       |             |           |          | inge in appetite     |           | A change in your health      |
|  | . 3                                     |             |           |          | iculty swallowing    |           | Numbness/Tingling            |
|  | Difficulty maintaining balanc           | e           |           | Pair     | n at night           |           | where?                       |
|  | Have you ever been diagnose             | d or und    | eraone t  | reatr    | ment for any of the  | followi   | ng (check all that apply)?   |
|  |   |             | 3         |          | Osteoporosis / Os    |           |                              |
|  | Type: Wher                              | า:          |           |          | Rheumatoid arthr     |           | ,                            |
|  | High Cholesterol                        |             |           |          | Osteoarthritis       |           |                              |
|  | High Blood Pressure                     |             |           |          | Thyroid problems     |           |                              |
|  | Angina / Chest Pain                     |             |           |          | Chemical depende     | ency      |                              |
|  | Stroke / Peripheral Artery Dis          | sease /     |           |          | Eating Disorder      |           |                              |
|  | Neuropathy (circle all that ap          | ply)        |           |          |                      |           |                              |
|  | Blood Clot                              |             |           |          | Neurological Diso    | rder (ty  | /pe:)                        |
|  | Anemia                                  |             |           |          | Lung Condition/D     | isease    | (type:)                      |
|  | Diabetes                                |             |           |          | Immunosuppressi      | on or co  | ompromised                   |
|  |   |             |           |          | Other:               |           |                              |
|  | Plaaca li                               | ict All ci  | urrant m  | odica    | ations (not just for | thic iniu | un ()                        |
| 1.   | i lease ii                              | ISC ALL C   | on encin  | cuice    | icions (noc josc for |           | ,, y).                       |
| 2.   |   |             |           |          |                      |           |                              |
| 3.   |   |             |           |          |                      |           |                              |
| <b>4</b> .   |   |             |           |          |                      |           |                              |
|  | nl r                                    |             |           |          |                      |           |                              |
|  | Please list any surgeries, ma           | ıjor injuri | es, or ot | ner c    | onditions requiring  | g hospit  | alization (include date):    |
| 1.   |   |             |           |          |                      |           |                              |
| 2.<br>3.   |   |             |           |          |                      |           |                              |
| ۶۰<br>4.   |   |             |           |          |                      |           |                              |
| Are you allergic to any of the following (check all that apply)? |   |             |           |          |                      |           |                              |
|  |   |             |           |          |                      |           |                              |
|  | Latex                                   |             |           |          | Hard work ©          | •         | • • •                        |
|  | Metal                                   |             |           |          | Other:               |           |                              |
| In the   | past month have you been bo             | thered b    | y having  | ı little | e interest or pleasu | re in do  | ing things? YES NO           |
| Are y  | ou pregnant?                            | Yes         | No        | May      | be                   |           |                              |
|  | υ have a pacemaker?                     | Yes         | No        | ,        |                      |           |                              |
|  | υ live alone?                           | Yes         | No        |          |                      |           |                              |
| •  | u have stairs in your home?             | Yes         | No        |          |                      |           |                              |
| -  | u smoke?                                | Yes         | No        |          |                      |           |                              |

Signature: Date: \_\_\_

What is your occupation:



## "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.

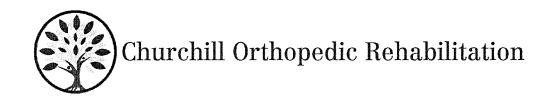
## **Patient Agreement**

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;



- 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:       |  |
|-----------------------|--------------------|-------------|--|
|                       | nt/Legal Guardian) | <del></del> |  |
| Print Name:           |                    |             |  |
| Relationship to the F | Patient            | Date:       |  |

T: 201-833-1333 • F: 201-833-1390 • churchillorthopt@gmail.com www.churchillorthopt.com

## 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 In   | nformation, 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 co  | mmunications, unless you object to this. As provided in our   |  |  |
| notice, the terms of our notice may chang   | ge. 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 Practice   | (Please print patient name) have received a copy of the ctices, for review and/or I have been given a copy if one was |  |  |
| requested.  |   |  |  |
| I understand that I may ask COR question  | ns if I do not understand any information contained in the Notice   |  |  |
| of Privacy Practices.   |   |  |  |
| ·   |   |  |  |
| You may disclose health information, F  | 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  |   |  |  |
| Palationship  | #   |  |  |