CORE PHYSICAL THERAPY & REHABILITATION

PATIENT REGISTRATION

Patient Information

Your Name:				Today's Date:
Date of Birth:	Age:	Height:	Weight:	Social Security #:

☐ Female ☐ Male	☐ Single ☐ Married ☐ Divorced ☐ Widowed

How did you hear about us? ☐ Doctor ☐ Past Patient ☐ Internet ☐ Family/Friend_____	
Home Address:	
City, State, Zip:	
Cell Phone #:	Home Phone #:
Email Address:	
Employer:	
Occupation:	
Address:	
Work Phone #:	

Emergency Contact:	
Relationship to Patient:	Phone #:

Referring Physician:
Primary Physician: (if different than referring)

Responsible Party Information (Parent/Guardian must complete if patient is under 18)

Name:	DOB:
Phone #:	
Home Address:	
City, State, Zip:	

AUTHORIZATION FOR CARE/ INFORMED CONSENT

I/we hereby authorize to receive care at Core Physical Therapy & Rehabilitation. **I/we understand that receiving physical therapy may involve stress of musculoskeletal tissue that may cause soreness**. Additional risks include, but are not limited to cardiovascular, muscle, ligament, joint, or disc injury. Symptomatic aggravation of your current condition is possible. Furthermore, I/we understand that the provider may need to perform mobilization technique, manipulation technique, massage technique, manual traction, distraction, and other movement modalities and services that may produce brief (several days) soreness and discomfort. **It is my/our responsibility to communicate any difficulties that I/we are having during treatment or any medical or activity changes to my/our provider.**Please acknowledge consent with full knowledge of the nature and risks of the evaluation and treatment program with your initials.

(Initial) _____

ASSIGNMENT & RELEASE (For All Patients)

I, the undersigned, assign directly to Core Physical Therapy & Rehabilitation, LLC all medical benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by my insurance.** I hereby authorize the physical therapist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. **I also understand that if I have a co-pay it will be due at the time of service.** Medicare Authorization: I request that payment of authorized Medicare or Medigap benefits be made on my behalf to Core Physical Therapy & Rehabilitation, LLC for any services furnished to me by a physical therapist. I authorize any holder of medical information about me to release to the CMS and its agents any information needed to determine these benefits or the benefits payable for related services. If a secondary insurance is listed or provided, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

(Initial) _____

PAYMENT POLICY

Core Physical Therapy will bill your insurance company directly if you have provided us with all the necessary information to do so. The physical therapy services that you receive and the bill, is an agreement between you and Core Physical Therapy. Core Physical Therapy will require a copy of your credit card to run all open balances and/or a copy of your Care Credit Card. **It is ultimately your responsibility to see that your physical therapy bill is paid in full.** Agreements with insurance companies vary greatly and it is your responsibility to know what is their portion and what is yours. Any remaining money unpaid by your insurance company will be your responsibility to pay in a timely manner. Your balance statement you will receive will reflect what your insurance company, upon verification, told us is your portion to pay. We expect this payment within 30 days. **If payment is not received within this 30-day period, a finance charge will be assessed per month. In the event a check is returned for any reason, a $35.00 charge will be made to your account. You agree to pay all costs and expenses. Amounts turned over to collections will be subject to a 25% collection fee.** You are responsible for payment regardless of any insurance company's arbitrary determination of medical necessity. PT Plus Services are not covered by insurance and must be paid in full at the time of service. The parents (or guardians) accompanying a minor are responsible for payment of the minor's treatment.

(Initial) _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose your protected information. I acknowledge that I have been offered the Core Physical therapy & Rehabilitation, LLC notice of Privacy Practices.

By signing below, I acknowledge that I have read and agree with the Core Physical Therapy's Authorization of Care/ Informed Consent, Assignment and Release, Medicare Authorization (if applicable), Payment Policy, and Acknowledgement of Privacy Practices

Signature: **X** _____ Today's Date: _____

Past Medical History

Do you have or have you ever been diagnosed with any of the following? Please circle Y or N below

Arthritis	Y / N	Epilepsy/ Seizures	Y / N	Pacemaker	Y / N
Bladder Problems	Y / N	Gout	Y / N	Psychological Problems	Y / N
Blood Clot/ Emboli	Y / N	Headaches	Y / N	Respiratory Problems	Y / N
Bowel Problems	Y / N	Hearing Problems	Y / N	Sleeping Problems	Y / N
Cancer	Y / N	Heart Condition	Y / N	Stroke/ TIA	Y / N
Chest Pain	Y / N	Hepatitis	Y / N	Thyroid Trouble	Y / N
Currently Pregnant	Y / N	High Blood Pressure	Y / N	Tuberculosis	Y / N
Do you smoke?	Y / N	HIV/ AIDS	Y / N	Vision Problems	Y / N
Diabetes	Y / N	Numbness/ Tingling	Y / N	Weight Loss/ Gain	Y / N
Dizziness/ Fainting	Y / N	Osteoporosis	Y / N	Other:	Y / N
Energy Loss	Y / N	Do you have an advanced directive?			Y / N

Please list any allergies: _____

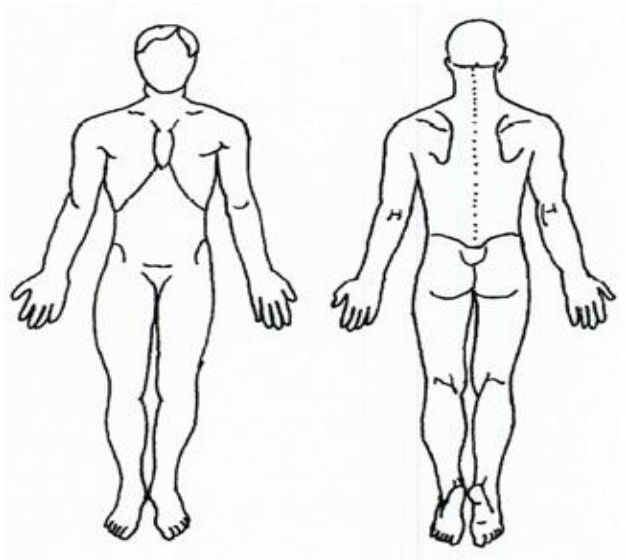
Currently, would you describe your overall health as: (circle one) Excellent, Good, Average, Below Average, Poor	
At the present time, whom do you live with? (Circle all that apply)	Alone, Spouse/Significant Other, Child(ren), Relatives, Group Setting, Parents
Do you have a safe home environment? (circle one) Yes / No If no, please discuss this with your therapist.	

Past Orthopedic Medical History

Please Indicate any previous orthopedic injuries or surgeries.

Neck Injury/ Surgery	Y / N
Shoulder Injury/ Surgery	Y / N
Elbow Injury/ Surgery	Y / N
Hand Injury/ Surgery	Y / N
Back Injury/ Surgery	Y / N
Hip Injury/ Surgery	Y / N
Knee Injury/ Surgery	Y / N
Ankle/ Foot Injury/ Surgery	Y / N
Have you had any falls in the past year?	Y / N

Please mark your areas of pain on the diagram below.



Liberty Office
556 Rush Creek Pkwy, Ste C – Liberty, MO 64068
Phone: (816) 792-0524 Fax: (816) 792-2897

Kansas City Office
5400 N Oak Trfy, Ste 103 – KCMO 64118
Phone: (816) 455-0301 Fax: (816) 455-0303

Medication Profile				
Name of Medication:	Dosage Amount:	Frequency:	By Mouth?	By Injection?

* Please note: Even if you are not taking any medications, please write 'None' on the Medication Profile and sign your name below.

Patient Signature: _____ Date: _____

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CANCELLATION POLICY

Here at CORE we pride ourselves on our individualized care and flexible schedule. This flexible schedule depends on having open slots to add/move appointments on short notice. We understand that things come up, and you may not be able to attend your scheduled appointment. All we ask is that you call and cancel/reschedule at least 24 hours in advance. This opens up your appointment time for someone else to be seen, and aids us in keeping our schedule flexible for our patients. If you fail to cancel your appointment in advance and/or miss your appointment our Same Day Cancellation Fee of $25.00 will be automatically charged to your account. Please sign below to indicate that you have read and agree with this policy. Thank you!

Signature: _____ Date: _____

AUTHORIZATION FORM FOR USE OF PHOTOGRAPHS/ SUCCESS STORIES IN PUBLIC RELATIONS AND MARKETING ACTIONS

PHOTOGRAPHY CONSENT FORM / RELEASE

I, (print name)_____, hereby grant permission to Physical Therapy Practice representatives, to take and use: photographs, video, and/or digital images of me for use in news releases and/or educational materials. These materials may include printed or electronic publications, Web sites or other electronic communications. I further agree that my name and identity may be revealed in descriptive text or commentary in connection with the image(s). I authorize the use of these images without compensation to me. All negatives, prints, and digital reproductions shall be the property of Physical Therapy Practice.

_____
(Date)

_____
(Signature of adult subject)

_____
(Address)

_____
(City, State, Zip)

RELEASE FOR MINOR CHILDREN (Under 18)

I, (print name)_____, parent or official guardian of (child's name)_____hereby grant permission to Physical Therapy Practice

representatives, to take and use: photographs, video, and/or digital images of **my child** for use in news releases and/or educational materials. These materials may include printed or electronic publications, Web sites or other electronic communications. I authorize the use of these images without compensation to me. All negatives, prints, and digital reproductions shall be the property of Physical Therapy Practice.

_____
(Date)

_____
(Signature of Parent or Guardian)

_____
(Address)

_____
(City, State, Zip)