From The Heart™
PHYSICAL THERAPY

Patient Registration

Patient Name: _____ **Date of Birth:** _____

Residence Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Sex: F / M **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Cell Phone #: _____ **Home Phone #:** _____ **Work #:** _____

Email: _____ **Social Security Number:** _____-_____-_____

Driver's License #: _____ **Occupation:** _____

Physician's Name: _____ **Physician's Phone:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone #:** _____

Medical History

1. Have you ever had or been diagnosed with any of the following?

High Blood Pressure	Yes	No	Dizzy Spells	Yes	No
Heart Trouble	Yes	No	Diabetes	Yes	No
Circulation Issues	Yes	No			
Seizures	Yes	No	Other _____		

2. List all surgeries and dates below:

Procedure:	Date:	Procedure:	Date:
(1) _____	_____	(3) _____	_____
(2) _____	_____	(4) _____	_____

3. Do you have a cardiac (heart) pacemaker? Yes No

4. Please list any known allergies: _____

5. WOMEN: Are you pregnant? Yes No Date of last menstrual cycle: _____

To the best of my knowledge, I certify that the above information is true and correct.

Patient Signature: _____ **Date:** _____

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Patient Symptom Overview

Patient Name: _____ **Date:** _____

1. **Are you currently working?** Yes No (If not, please indicate last day worked _____)

2. **Describe the physical demands of your occupation:** _____

_____

3. **Describe your main complaints and symptoms:** _____

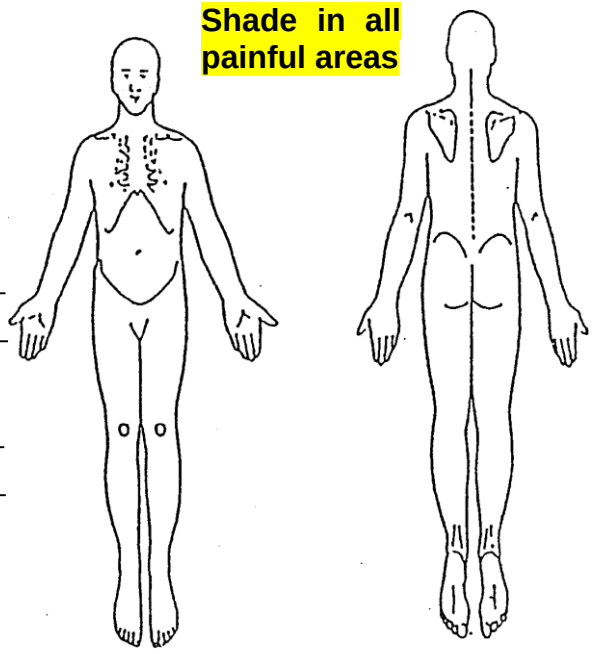
_____

4. **Please rate your pain:** 1 2 3 4 5 6 7 8 9 10

5. **Circle how you would describe your pain.** *(use all that apply)*

Sharp Dull Aching Tingling
Numb Constant Variable Radiating (moves)

Shade in all painful areas



6. **How did the symptoms start?**

_____

_____

7. **What positions or activities make your pain worse?**

_____

_____

8. **What positions or activities make your pain better?**

_____

_____

9. **Have you received any treatment or undergone any tests for your current problem?**

_____

10. **Have you ever had physical therapy treatments?** Yes No *If yes, please specify:*

_____

11. **Do you have metal implants?** Yes No *(If yes, explain)*

_____

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CONSENT TO TREAT

I, _____, hereby consent to routine physical therapy services as provided by From the Heart Physical Therapy under the supervision of a licensed Physical Therapist. I acknowledge that treatment may include any number of manual procedures, Myofascial Release techniques, exercises and/or modalities that will be rendered as part of the physical therapy treatment program provided by this office.

ACCEPTANCE OF OFFICE POLICIES & FINANCIAL AGREEMENTS

- A valid credit card is required to secure appointment reservations and will be held on-file for future visits. Visa and MasterCard are accepted. **Patient Initials:** _____

- Patients must provide a 48-hour advance notification to cancel or reschedule appointments. If less than 48-hours' notice is given; the patient will be held accountable for the full amount of the service charged to the credit card on file. **Patient Initials:** _____

- Your appointment time is set-aside solely for you; therefore, we appreciate you being on-time. Late arrivals will result in abbreviated treatment time.

- It is your responsibility to notify the office of any change in address, phone, employment, or insurance coverage.

- For **private patients**, payment is required at the time services are rendered. We accept checks, cash, debit, and credit cards. We do not bill insurances other than Medicare as per eligible benefits and will provide a Superbill upon your request. If we receive a payment from your insurance company, we will issue a refund check to your address on-file.

- For **Medicare insured patients**, Patients will accept full financial responsibility if for any reason Medicare does not pay From the Heart Physical Therapy for their treatments. Patients need to communicate any changes made to their Medicare, Secondary policy or coverage immediately. Our office will submit claims to Medicare only up to the first cap of $2040. If a patient pays for uncovered services and if we receive payment from Medicare, we will issue a refund check to the patient's address on file.

- Patient Statements*:* All balances are due in full within 14 days of the statement date. We reserve the right to charge all accounts with a balance over 30 days from billing date a service charge of 1.5% per month. We reserve the right to submit your account in a collection program, report delinquent accounts to credit bureaus, assess a collection fee of up to 40% of the outstanding balance, take other collection action, and/or terminate you as a patient of this practice. In addition, if legal action is taken you will be responsible for the cost, which may be up to $250.00 per hour.

I have read the Office Policies and Financial Agreements and agree to abide by all terms in this document:

Patient Signature: _____ **Date:** _____

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Release of Medical Information

Patient Name: _____

Medical Facility: _____

You are hereby authorized and requested to furnish any and all medical information, history, records, diagnosis, reports and/or radiographs in your possession regarding the above named patient to From The Heart Physical Therapy.

Patient Signature: _____ Date: _____

HIPAA Privacy Authorization

**Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164) **

1. Authorization: I authorize From The Heart Physical Therapy to use and disclose the protected health information described below to _____ (individual or entity seeking the information).

2. **(Initial: _____)** Effective Period: This authorization for release of information covers the period of healthcare for all past, present, and future periods while under the care at From the Heart Physical Therapy.

3. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

4. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

5. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient Signature: _____ Date: _____

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