



# Patient Registration Form

## PATIENT INFORMATION

Patient Name:			Account Number:		
Date of Birth:	Age:	SS#:	Gender:		
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Unknown					
Home Phone:		Cell:	Work:		
Email:					
Address:					

## EMPLOYER INFORMATION:

Employer:	Employment Status: <input type="checkbox"/> Active Military <input type="checkbox"/> Full-Time <input type="checkbox"/> None <input type="checkbox"/> Part-Time <input type="checkbox"/> Retired <input type="checkbox"/> Self Employed
Address:	
Phone:	Occupation:

## INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Policy #:	Policy #:
Group #:	Group #:
Subscriber's Name:	Subscriber's Name:
Subscribers DOB:	Subscribers DOB:
Relation to Patient:	Relation to Patient:

## INJURY INFORMATION

My Injury is Related To: \_\_\_ Work \_\_\_ Auto \_\_\_ Sports \_\_\_ None DOI:

Injury Area: Referring Doctor:

## WHY DID YOU CHOOSE PHOENIX REHABILITATION (Choose one)

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Accommodating Hours | <input type="checkbox"/> Attorney                    | <input type="checkbox"/> Billboard             | <input type="checkbox"/> Convenient Location  |
| <input type="checkbox"/> Email               | <input type="checkbox"/> Employer                    | <input type="checkbox"/> Family                | <input type="checkbox"/> Former Patient       |
| <input type="checkbox"/> Friend              | <input type="checkbox"/> Insurance Carrier           | <input type="checkbox"/> Internet Search       | <input type="checkbox"/> Medical Office Staff |
| <input type="checkbox"/> Medical Provider    | <input type="checkbox"/> Online Reviews/Ratings      | <input type="checkbox"/> Other                 | <input type="checkbox"/> PHOENIX Website      |
| <input type="checkbox"/> Print Ad            | <input type="checkbox"/> Self Referral/Direct Access | <input type="checkbox"/> Sign                  | <input type="checkbox"/> Social Media         |
| <input type="checkbox"/> Specialty Program   | <input type="checkbox"/> Therapist's Certification   | <input type="checkbox"/> WC Panel of Providers |   |

## RESPONSIBLE PARTY (Guarantor)

Name:	Date of Birth:
Phone:	Relation:

## EMERGENCY CONTACT

Emergency Contact Name:	
Emergency Contact Relation:	Emergency Contact Phone:



# FINANCIAL POLICY AND CONSENT

Patient Name: \_\_\_\_\_

Account Number: \_\_\_\_\_

We would like to **THANK YOU** for choosing PHOENIX Rehabilitation and Health Services, Inc. PHOENIX Rehabilitation and Health Services, Inc. accepts third party payments and will submit your bills for treatment to the address provided as a courtesy to you. In order for us to bill your insurance company on a regular basis, we request that you sign this release of information and assignment of benefits (if applicable). Typically, insurances pay a predetermined amount of our treatment charges; however, it is your responsibility to call your insurance company to check on the coverage provided by your individual policy. As a courtesy to you, we will perform an insurance verification with your insurance company; however, we will not take responsibility for any misinformation that we are given during this process. Therefore, it is within your best interest to verify your outpatient benefits with your individual insurance plan and to confirm them with our office prior to initiating treatment.

## **CONSENT FOR CARE AND TREATMENT**

I hereby give written consent for the provision of treatment. I authorize PHOENIX Rehabilitation and Health Services, Inc. to furnish treatment which is considered necessary and proper in diagnosing or treating my physical condition.

## **FINANCIAL RESPONSIBILITY**

I understand that in some instances the applicable insurance may not cover all treatment charges incurred. I agree to be financially responsible to PHOENIX Rehabilitation and Health Services, Inc. for any medically necessary therapeutic services that are deemed uncovered by my insurance policy.

## **ASSIGNMENT OF BENEFITS**

I hereby authorize payment directly to PHOENIX Rehabilitation and Health Services, Inc. any benefits payable to me and/or my qualified dependents under the insurance coverage or Major Medical provisions of insurance coverage identified on bills submitted by PHOENIX Rehabilitation and Health Services, Inc. for treatment. By way of my signature below, I provide PHOENIX Rehabilitation and Health Services, Inc. with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment and health care operations as described in the Notice of Privacy Practices.

## **CO-PAYMENTS, COINSURANCE AND DEDUCTIBLES**

I understand that if my insurance plan requires a co-payment, coinsurance, and/or deductible for treatment, payment will be collected at the time of my visit, according to my insurance benefits and the following PHOENIX Rehabilitation and Health Services policy to reduce the balance billed to me at the end of care: Copays are collected in full. \$10 per visit is due **towards** 10% coinsurance, \$20 per visit **towards** 20% coinsurance, etc. \$50 per visit is due **towards** a deductible.

## **LITIGATION ACCOUNTS**

I understand that PHOENIX Rehabilitation and Health Services, Inc. will directly bill my appropriate insurance; however, I am responsible for the payment of my treatment, not the entity being sued. Liability action against someone else will not enable me to refuse payment to PHOENIX Rehabilitation and Health Services, Inc.

## **PATIENT VALUABLES**

I relieve PHOENIX Rehabilitation and Health Services, Inc. of any responsibility for loss of clothing, money, valuables, or other items that I decide to keep with me while I am a patient. I also understand that PHOENIX Rehabilitation and Health Services, Inc. will not be responsible and will not replace any property lost, broken, or stolen, which I decide to keep with me, or any property brought to me while I am a patient.

## **CONSENT TO RECEIVE EMAIL, TEXT MESSAGES, AND CALLS FOR APPOINTMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS**

I consent to receive email, text messages, and calls from PHOENIX Rehabilitation and Health Services, Inc. for my protected health care and other services at the email address and phone number(s), including my wireless number, that have been provided during the intake process. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system. I understand that providing an email address and/or phone number is not a condition of receiving treatment. I am aware that e-mail communication can be intercepted in transmission or misdirected. I also understand that I may revoke my consent for contact at any time by directly contacting PHOENIX Rehabilitation and Health Services, Inc. or utilizing the opt-out method that will be identified in the applicable communication.

Patient Name: \_\_\_\_\_

Account Number: \_\_\_\_\_

**CERTIFICATION OF IDENTITY**

I certify that I am in fact the individual I claim to be. I understand that the knowing and willful use of another individual's personal identifying information under false pretenses is a criminal offense.

**FOR PHOENIX REHABILITATION AND HEALTH SERVICES INC. OFFICE USE ONLY**  
**Verification of the identity of the above-named party was made by:**

Current Driver's License or other Photo ID

Current Health Insurance Card

Other:

\_\_\_\_\_  
**Signature of PHOENIX Rehabilitation and Health Services Inc. Representative**

\_\_\_\_\_  
**Date**

**I ACKNOWLEDGE THAT I READ AND UNDERSTAND ALL COMPONENTS OF THE PHOENIX REHABILITATION AND HEALTH SERVICES INC. POLICIES AS STATED ABOVE.**

\_\_\_\_\_  
**Signature of Patient or Guardian (if patient is a minor)**

\_\_\_\_\_  
**Date**



**Acknowledgement of Receipt of Privacy Notice**

**Purpose of this Acknowledgement**

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or health care operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

***Please read the following information carefully:***

- 1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by PHOENIX Rehabilitation and Health Services, Inc. (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any health care operations that are permitted in the Privacy Regulations.
- 2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.
- 3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: 430 Innovation Drive, Blairsville, PA 15717, Attention: Compliance Officer.
- 4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or health care operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me except in very limited circumstances as described in the Privacy Notice, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions):

\_\_\_\_\_

\_\_\_\_\_

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and health care operations.

**BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.**

\_\_\_\_\_  
**Signature of Patient or Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Patient's Name**

\_\_\_\_\_  
**DOB**

\_\_\_\_\_  
**Name of Personal Representative (if applicable)**

\_\_\_\_\_  
**Relationship to Patient**

***To Be Completed by the Practice***

The requested restrictions on the use and/or disclosure of the patients health information set forth above are:

Accepted \_\_\_\_\_ Denied \_\_\_\_\_ Not Applicable \_\_\_\_\_

Other (explain) \_\_\_\_\_

Signature of Authorized Practice Representative: \_\_\_\_\_ **Date:** \_\_\_\_\_



# Injury and Past Medical History Questionnaire

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

When did the condition for which you are seeking treatment begin? \_\_\_\_\_

Please describe the history and onset of the present condition: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Date of Surgery (if applicable): \_\_\_\_\_ Type of Surgery: \_\_\_\_\_

What are your chief complaints due to your condition? Please check all that apply.

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Awakened by pain                                   | <input type="checkbox"/> Headaches                  | <input type="checkbox"/> Pain worse in the AM     |
| <input type="checkbox"/> Burning  | <input type="checkbox"/> Irritability               | <input type="checkbox"/> Pain worse in the PM     |
| <input type="checkbox"/> Difficulty falling asleep                          | <input type="checkbox"/> Loss of function           | <input type="checkbox"/> Pain worse with activity |
| <input type="checkbox"/> Difficulty finding a comfortable sleeping position | <input type="checkbox"/> Loss of motion - stiffness | <input type="checkbox"/> Spasm                    |
| <input type="checkbox"/> Difficulty walking                                 | <input type="checkbox"/> Nausea                     | <input type="checkbox"/> Swelling                 |
| <input type="checkbox"/> Diminished motion                                  | <input type="checkbox"/> Numbness                   | <input type="checkbox"/> Tingling                 |
| <input type="checkbox"/> Dizziness  | <input type="checkbox"/> Pain                       | <input type="checkbox"/> Weakness                 |
| <input type="checkbox"/> Fatigue  | <input type="checkbox"/> Constant Pain              | <input type="checkbox"/> Other _____              |

If you have pain, please rate your pain today on a scale of 0 to 10? (0 is no pain, and 10 is worst possible pain or symptoms): \_\_\_\_\_ /10

Where is your pain located and how would you describe it? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Rate your symptom intensity in the past 5 days: \_\_\_\_\_ Symptoms at their worst: \_\_\_\_\_ /10

Symptoms at their best: \_\_\_\_\_ /10

Please list any contraindications to treatment or precautions that we should know: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Occupation: \_\_\_\_\_

- Work Status:
- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Employed Full Time | <input type="checkbox"/> Employed Part Time | <input type="checkbox"/> Not employed         |
| <input type="checkbox"/> Full time student  | <input type="checkbox"/> Part time student  | <input type="checkbox"/> Permanently Disabled |
| <input type="checkbox"/> Retired            |   |   |

- Current Ability to work:
- |   |   |                                   |
|---|---|-----------------------------------|
| <input type="checkbox"/> Full Duty                  | <input type="checkbox"/> No formal restrictions | <input type="checkbox"/> Off work |
| <input type="checkbox"/> Restricted duties/schedule |   |                                   |
- Please outline restrictions: \_\_\_\_\_
- \_\_\_\_\_

- Normal work duties:
- |  |  |
|--|--|
| <input type="checkbox"/> Sitting for extended periods  | <input type="checkbox"/> Lifting moderate weights  |
| <input type="checkbox"/> Standing for extended periods | <input type="checkbox"/> Lifting Heavy Weights     |
| <input type="checkbox"/> Typing/computer operation     | <input type="checkbox"/> Walking                   |
| <input type="checkbox"/> Repetitive Bending            | <input type="checkbox"/> Operating Heavy Equipment |
| <input type="checkbox"/> Repetitive Lifting            | <input type="checkbox"/> Driving                   |

Which of these duties are you not currently able to perform and why? \_\_\_\_\_

\_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Please list any surgeries and procedures		
Type of Surgery	When	Results/Details

Please list any diagnostic tests and results related to your current condition		
Test	When	Results/Details

Please list other specialists seen for your current condition other than prescribing physician			
Name	Specialty	Reason	Date of Last Visit

Please enter your current height: \_\_\_\_\_ Please enter your current weight: \_\_\_\_\_

Please mark beside all conditions that you have a history of:

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Allergies         | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Mental/Cognitive Disorder | <input type="checkbox"/> Pregnancy (current)  |
| <input type="checkbox"/> Anxiety           | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Metal Implants            | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Heart Condition     | <input type="checkbox"/> Nausea/Vomiting           | <input type="checkbox"/> Shortness of Breath  |
| <input type="checkbox"/> Bowel Dysfunction | <input type="checkbox"/> History of Smoking  | <input type="checkbox"/> Neurological Disorder     | <input type="checkbox"/> Stroke/CVA           |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Osteoarthritis            | <input type="checkbox"/> Syncope/Fainting     |
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Joint Replacement   | <input type="checkbox"/> Osteoporosis              | <input type="checkbox"/> Recent Weight Change |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Malaise/Fatigue     | <input type="checkbox"/> Pacemaker                 | <input type="checkbox"/> Other _____          |

Please list all medications and supplements that you are presently taking			
Name of Medication/Supplement	Route of Administration (Oral, topical, etc)	Dosage	Frequency of Use

Have you fallen in the past 12 months?  Yes  No If so, how many times? \_\_\_\_\_

If you have fallen, did any fall result in an injury?  Yes  No  N/A

Have you recently been hospitalized?  Yes  No If so, when were you discharged? \_\_\_\_\_

Have you received therapy in the past 12 months?  Yes  No If yes, how many visits? \_\_\_\_\_

In what type of home do you live?  Single Level Home  2 Level Home  Ground Floor Apartment  
 Upper Level Apartment  Other: \_\_\_\_\_

With whom do you live?  Spouse  Parent(s)  Children  Alone  Other: \_\_\_\_\_

Are there stairs at home?  Yes  No If so, how many? \_\_\_\_\_

Is there a handrail?  Yes  No If yes,  Right Side only  Left Side only  Both Sides

Where is the bathroom located?  Lower Level  Upper Level

Where is the bedroom located?  Lower Level  Upper Level

Do you currently smoke?  Yes  No If so, how many packs per day? \_\_\_\_\_

Did you smoke in the past?  Yes  No If so, how many packs \_\_\_\_\_ years \_\_\_\_\_

What are your goals and what do you expect to achieve with treatment? \_\_\_\_\_