CHOICE Therapy Services
Registration Information

Patient Information (Please Print)							
Patient's Name:							
Responsible Party (if a minor)		Relationship to Patient					
Address							
City		State		Zip			
Home Phone #		Cell Phone #					
Email							
Are you interested in receiving important health related information via e-mail?		Yes		No			
SSN		Driver's License #					
Sex	□ M □ F	Age		DOB		Marital Status	□ Single □ Married □ Widowed □ Separated □ Divorced

Employer Information					
Employer					
Address					
City		State		Zip	
Phone #		Occupation			

Spouse's Information (or responsible party)					
Name		SSN			
Employer					
Address					
City		State		Zip	
Phone #		Occupation			

Emergency Information			
Name of nearest relative not living with you			
Phone #		Relation	

History (write on back if extra space is needed)

Why are you being seen today?

What other health care providers are you currently seeing or have seen within the last 2 years?

For what conditions?

What medications are you currently taking?

For what conditions?

How did you hear about us?

□ Medical Doctor □ Family □ Friend □ Ins. Company □ Driving by □ List from MD □ Newspaper Ad □ Phone Book

□ Other : ____

CHOICE Therapy Services
(Physical Therapy Referral)

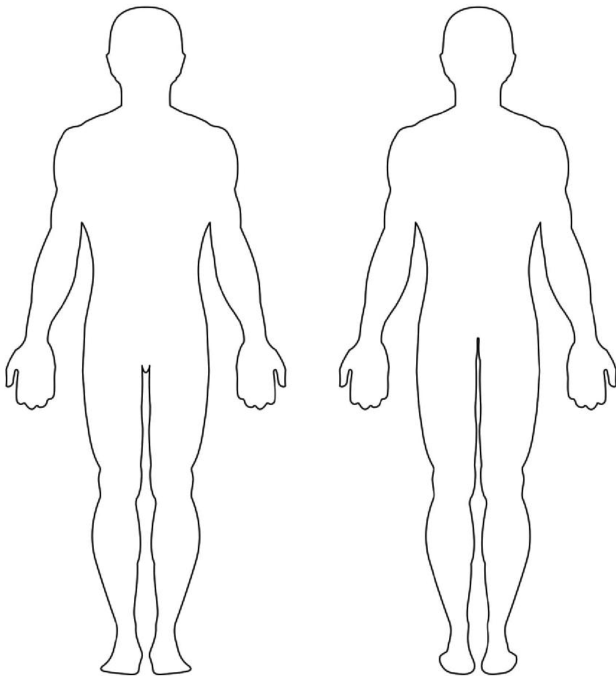
1. What body problem(s) are you hoping to correct with physical therapy?

2. What have you heard about physical therapy?

3. What is the goal you hope to achieve with therapy and why?

4. Do you have any concerns about physical therapy?

5. Where is your pain? Please mark on the drawings below the area(s) where you feel you pain.



6. Pain Scale. Please mark your pain on the line below.

(No pain) ____1 _____ 2 ____ 3 ____ 4 ____5 ____6 ____7 ____8 ____9 ____10 (Max pain)

CHOICE Therapy Services
Patient History

Name: ____ Date:_________________

Do you have a history of high blood pressure? Yes_____ No_____

Do you have a history of heart problems? Yes_____ No_____

Do you have a pacemaker implant? Yes_____ No_____

Do you have any metal implants (pins, plates, screws, IUD)? Yes_____ No_____

Do you have any sensory impairment? Yes_____ No_____

Are you pregnant? Yes_____ No_____

Do you have any history of diabetes? Yes_____ No_____

Do you have any history of cancer? Yes_____ No_____

Do you have any history of circulatory problems? Yes_____ No_____

Do you have any history of seizures? Yes_____ No_____

Do you have any history of broken bones? Yes_____ No_____

Do you have any history of head injury? Yes_____ No_____

Do you have any history of stroke? Yes_____ No_____

Do you have any vision/hearing problems? Yes_____ No_____

Specify ____

____

Do you have any history of any type of hepatitis? Yes_____ No_____

Have you had any unintended weight loss recently? Yes_____ No_____

Are you currently taking any medications? Yes_____ No_____

Please list any medications you are currently taking ______________________________________

____

Please list any surgeries you have had in the past ____

____

Have you ever had therapy before? Yes_____ No_____

Is there anything else in your medical history you think we should know?_____________________________

____

____

____

CHOICE Therapy Services

Pain Descriptions for ___________________________________

(patient name)

There are many words that describe pain. Some of these are grouped below. Check (√) any words that describe the pain you have experienced recently.

1.
- ☐ Flickering
- ☐ Quivering
- ☐ Pulsing
- ☐ Throbbing
- ☐ Beating
- ☐ Pounding

2.
- ☐ Jumping
- ☐ Flashing
- ☐ Shooting

3.
- ☐ Pricking
- ☐ Boring
- ☐ Drilling
- ☐ Stabbing

4.
- ☐ Sharp
- ☐ Cutting
- ☐ Lacerating

5.
- ☐ Pinching
- ☐ Pressing
- ☐ Gnawing
- ☐ Cramping
- ☐ Crushing

6.
- ☐ Tugging
- ☐ Pulling
- ☐ Wrenching

7.
- ☐ Hot
- ☐ Burning
- ☐ Scalding
- ☐ Searing

8.
- ☐ Tingling
- ☐ Itchy
- ☐ Smarting
- ☐ Stinging

9.
- ☐ Dull
- ☐ Sore
- ☐ Hurting
- ☐ Aching
- ☐ Heavy

10.
- ☐ Tender
- ☐ Taut
- ☐ Rasping
- ☐ Splitting

11.
- ☐ Tiring
- ☐ Exhausting

12.
- ☐ Sickening
- ☐ Suffocating

13.
- ☐ Fearful
- ☐ Frightful
- ☐ Terrifying

14.
- ☐ Punishing
- ☐ Grueling
- ☐ Cruel
- ☐ Vicious
- ☐ Killing

15.
- ☐ Wretched
- ☐ Blinding

16.
- ☐ Annoying
- ☐ Troublesome
- ☐ Miserable
- ☐ Intense
- ☐ Unbearable

17.
- ☐ Spreading
- ☐ Radiating
- ☐ Penetrating
- ☐ Piercing

18.
- ☐ Tight
- ☐ Numb
- ☐ Drawing
- ☐ Squeezing
- ☐ Tearing

19.
- ☐ Cool
- ☐ Cold
- ☐ Freezing

20.
- ☐ Nagging
- ☐ Nauseating
- ☐ Agonizing
- ☐ Dreadful
- ☐ Torturing

CHOICE Therapy Services
Financial Agreement

We would like to take a moment to welcome you to our office and assure you that you will receive the very best care available for your condition. In order to familiarize you with the financial policy of this office, we would like to explain how your medical bills will be handled.

Insurance Coverage
Most insurance policies cover therapy, but this office makes no representation that yours does. Insurance policies can differ greatly in terms of deductible and percentage of coverage for therapy. Because of the variance from one insurance policy to another, we require that you, the patient, are personally responsible for verifying benefits with your insurance company and for payment deductibles, as well as any unpaid balances in this office. We will bill your insurance company(ies) in a timely manner. Your co-payment and/or co-insurance are required prior to each treatment. Any over payments will be refunded to you. An interest charge of 1 ½% per month may be applied to your past due balance.

Assignment of Benefits
Attached is an “Assignment of Benefits” form that we would like you to sign. This form instructs your insurance company to send their payments directly to this office. Please sign all copies of this form. If your insurance carrier sends you payment for services incurred in this office, you shall send or bring the full payment to our office immediately upon receipt.

Rescheduling/Canceling Appointments
If it is necessary for you to re-schedule an appointment, please call at least 24 hours in advance. If you are a no-show twice for an appointment we will charge you a $25 service fee. This would not be covered by insurance and a bill will be sent to you directly. After a third time no-show, you will be billed an additional $25 service fee and discharged back to your referring physician with an explanation.

Voluntary Termination of Care
If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are billed to your insurance company and the balances will be charged directly to you, and you ultimately will be personally responsible for payment, regardless of your insurance coverage.

Attention Medicare Patients
We are a certified provider under Medicare Part B. Medicare has placed a financial cap on therapy benefits for a limitation of $1810.00 for outpatient therapy benefits. Medicare has a deductible of $135.00 and pays 80% of approved services. Please inform us if you have secondary coverage. If you have had therapy at another facility this calendar year, please advise us on your first visit.

Previous Patients
If you have received therapy from our office at a previous date and have a balance from a previous account, you will be required to pay no less than 50% of the balance and arrange a firm payment plan for the remaining balance prior to initiating a new account.

We hope that this answers any questions you might have concerning the financial policies of this office. Once again, we welcome you to our office and will be glad to answer any further questions you might have.

I have read and agree to the above.

Patient’s Signature: ____ Date: ____________________

CHOICE Therapy Services
Health Insurance Portability and Accountability Act Statement

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used in the below circumstances.

I understand and give authorization to CHOICE Therapy Services to make telephone calls to my home about my health related information and appointment reminders. A message may be left on my answering machine/voice mail.

I understand that a letter may be sent to my primary physician and other healthcare providers (i.e. chiropractor, dentist, massage therapist, OBGYN, surgeon, acupuncturist, other medical specialist) that I see for medical care informing him/her that I am currently having therapy. If he/she requests updates on my progress, I am giving authorization to CHOICE Therapy Services to send him/her copies of my progress reports that are also being sent to the referring physician. Please list below any EXCEPTIONS for providers that you do not authorize us to contact:

____

____

I hereby give my permission for authorized personnel of CHOICE Therapy Services to perform all necessary procedures and treatments outlined in the plan of treatment.

I hereby authorize a representative of CHOICE Therapy Services to be permitted to obtain and review copies of all hospital, medical, vocational, and other related records and to discuss pertinent information with professionals involved in my case.

EXCEPTIONS: (Please list) ____

In specific instances I also authorize CHOICE Therapy Services to share information regarding my rehabilitation to/from my employer. I understand that the information shared will be used to assist in tailoring my rehabilitation program to my specific job tasks. If applicable, name of employer/contact information:

____

This consent is to remain in effect until otherwise revoked by me in writing. I agree that a photocopy of this authorization be accepted if necessary.

I, ___________________________, have read and understand the above as well as the privacy notice provided to me by CHOICE Therapy Services.

Signature: ____ Date: ______________________

CHOICE Therapy Services
Co-Pay and Co-Insurance is Collected at Each Appointment

Co-Insurance is an estimated amount calculated by our billing department according to your insurance benefits.

Patients may receive a monthly bill for additional Co-Insurance due if we have under-estimated the amount after your insurance begins paying your claims. We will adjust your payment amount if necessary at that time.

This is a CHOICE Therapy Services business policy done to relieve the possible financial burden to our patients of receiving large monthly statements. Your insurance deducts the Co-Insurance you owe from their payments to CHOICE Therapy Services for your treatment. Since therapy is an on-going treatment, these un-paid portions due from patients can add up quickly.

Please understand that this is a service we provide to you. Many facilities do not do this and simply send a large monthly bill for Co-Insurance due in full in 30 days. We want you to be able to concentrate on your treatment and getting well quickly, not how you will pay your bill.

Thank you for your anticipated cooperation.

I have read the above

Patient Signature: ____

CHOICE Therapy Services
To Our Patients Regarding Cancellations and No-Shows

The following are our policies regarding cancellations and no-shows. We take this subject seriously at this clinic because it can make a difference between whether you succeed in your treatment or not. Your referring doctor has prescribed a set frequency of treatment visits and showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow our therapist's instructions and we will be able to help you achieve your goals in treatment.

- If it is necessary for you to reschedule an appointment, please call at least 24 hours in advance. When you call, please be prepared to reschedule that appointment to ensure you get in the full-prescribed number of treatments that week.

- Please be on time for all of your scheduled appointments. If you arrive 10 minutes after your treatment time, you may not be seen for your appointment. This appointment may be counted as a cancellation without prior notice.

- There is a $25 service fee for two (2) no-shows or cancellations without prior notice. This charge will not be covered by insurance and a bill will be sent to you directly. If you no-show or cancel without proper notice a third time, you will be billed a $25 service fee and discharged back to your referring physician with an explanation.

- For Worker's Compensation and Personal Injury patients, documentation of any missed appointments is forwarded to your Case Manager and Referring Physician and this could jeopardize your claim.

- You may need to see a therapist other than the one who normally treats you if you do reschedule an appointment. All of our therapists are experienced professionals, and they will study your patient chart, so you will be in good hands. You will return to your original therapist in the next regularly scheduled visit.

- Please understand that for physical or occupational therapy, if you have pain, it will probably increase and decrease as your course of treatment progresses. Neither of these conditions is legitimate as a reason skip an appointment: a) if you're in pain, come in and we can help to alleviate it, b) if your pain has decreased, now is the time that we can do more correction of the underlying causes of your problem and educate you to prevent further injury.

- When you don't show up as scheduled, three people are hurt: 1) You, because you don't get the treatment you need as prescribed by the doctor, 2) the therapist, who now has a space in their schedule since the time was reserved for you personally, and 3) another patient who could have been scheduled for treatment if you had given proper notice.

Please co-operate with us in this regard. We are looking forward to working with you to achieve your best possible outcome!

Patient Name: ____

Patient Signature ____ Date _______________________

CHOICE Therapy Services
Assignment and Instruction for Direct Payment to Health Provider

Patient: ____

Address: ____

City: ____State: __________ Zip: ________

Insurance Company: ____

Claim or Group #: ____

I hereby instruct the above named Insurance Company to pay directly to:

CHOICE Therapy Services

For professional or medical expense allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED EFFECTIVE AND VALID AS THE ORIGINAL

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, attorney or state appeal board for the purpose of securing payment under this policy or insurance.

Signature of Policy Holder: ____

Date: ____________________________________

Signature of Claimant, if other that Policy Holder: _____________________________________