

# Callan-Harris Physical Therapy, PC

## MESSAGE REGISTRATION FORM

### PATIENT INFORMATION

Patient's Last Name		First	Middle	<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Marital Status				
				<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	<input type="checkbox"/> Sgl	<input type="checkbox"/> Mar	<input type="checkbox"/> Div	<input type="checkbox"/> Sep	<input type="checkbox"/> Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former Name)		Birth Date		Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F		
Street Address		City	State	ZIP Code	Cell Phone No. ( )		Home Phone No. ( )			
Primary Care Physician <input type="checkbox"/> Dr.							Doctor's Phone No. ( )			
Doctor's Address		City	State	ZIP Code	Doctor's Fax No. ( )					
E-mail address										

### IN CASE OF EMERGENCY

Name of Local Friend or Relative (if possible, someone not living at same address)		Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )
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The above information is true to the best of my knowledge and I authorize treatment. I authorize my insurance benefits to be paid directly to Callan-Harris PT, PC. I understand that I am financially responsible for any balance. I also authorize Callan-Harris Physical Therapy, PC or insurance company to release any information required to process my claims.

X \_\_\_\_\_  
 PATIENT / GUARDIAN SIGNATURE DATE

### Patient consent form (HIPPA)

By signing this form, you are granting consent to Callan-Harris Physical Therapy to use and disclose your protected health information for the purpose of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent and we encourage you to read it in full.  
 (There is a copy hanging on bulletin board in the waiting room, or you may ask for your own personal copy.)

Our Notice of Privacy Practices is subject to change. If we change our notice, we will post it in the waiting room. We encourage you to request a copy of the revised policy.

You have the right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I verify that I have been offered a copy of Notice of Health Information Privacy Practices Initial \_\_\_\_\_

## **FINANCIAL AGREEMENT**

I acknowledge that payment is due at the time of treatment. I agree that parents, guardians, or other personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all services or items provided to me, to my minor/child, or to the patient to whom I have legal responsibility.

SELF PAY patients are required to pay in full for charges incurred at the time services are rendered. Payment plans are available as a courtesy – please speak with the office manager to set this up.

I understand that a \$25.00 fee will be charged for any returned checks.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

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

## **APPOINTMENT CANCELLATION POLICY**

### *Important information for our patients:*

Our Physical Therapy Practice requires a 24 hour notice for all cancellations. If a scheduled appointment must be cancelled within 24 hours of the scheduled time, **there will be a charge equal to your co-payment (or a fee of \$20.00 if your insurance does not require a co-payment for visits to a specialist). If you are a no show for your appointment, the same charge will be applied.** We are holding the time spot for you and may be able to give the time to another patient who has requested a visit.

Should you have more than 3 cancellations on day of appointment and/or missed appointments- you will only be allowed to call in on the day you would like to be seen to see if any appointments are available.

Initial \_\_\_\_\_ Date \_\_\_\_\_

Parent or guardian's initials (if under age 18) \_\_\_\_\_

Callan-Harris Physical Therapy, PC  
Patient Medical History/Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Are you taking any prescription or over-the-counter drugs? Yes No If yes, please list each one below:

\_\_\_\_\_

Height: \_\_\_\_\_ Weight \_\_\_\_\_

Do you currently smoke? Yes No If yes, how much? \_\_\_\_\_

Have you previously smoked? Yes No If yes, how long before you quit? \_\_\_\_\_

If you are a female, could you be pregnant or are you attempting to become pregnant? Yes No

What is the furthest you could walk before taking a break? (time or distance) \_\_\_\_\_

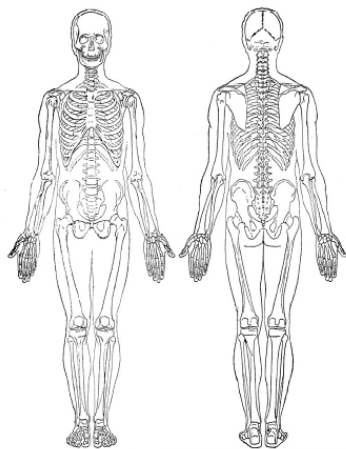
Have you ever had and/or been treated for any of the following disease or medical problems? (check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Abnormal Bleeding                    | <input type="checkbox"/> Gastrointestinal Problems _____       |
| <input type="checkbox"/> Anemia                               | <input type="checkbox"/> Hay Fever                             |
| <input type="checkbox"/> Asthma, wheezing, or inhaler use     | <input type="checkbox"/> Head Injury _____                     |
| <input type="checkbox"/> Arthritis (osteo, rheumatoid) _____  | <input type="checkbox"/> Heart Disease, irregular pulse        |
| <input type="checkbox"/> Back/Neck pain/problems              | <input type="checkbox"/> Hearing or Vision Loss/Disturbance    |
| <input type="checkbox"/> Balance Problems                     | <input type="checkbox"/> High / Low Blood Pressure _____       |
| <input type="checkbox"/> Broken Bones _____                   | <input type="checkbox"/> Heart Murmur/Mitral Valve Prolapse    |
| <input type="checkbox"/> Cancer/Chemotherapy/Radiation/Tumors | <input type="checkbox"/> Heart Surgery/ Pacemaker              |
| <input type="checkbox"/> Circulation/Vascular problems        | <input type="checkbox"/> Hepatitis A, B, C                     |
| <input type="checkbox"/> Deep Vein Thrombosis                 | <input type="checkbox"/> Kidney Problems _____                 |
| <input type="checkbox"/> Depression or Anxiety                | <input type="checkbox"/> Multiple Dystrophy/Multiple Sclerosis |
| <input type="checkbox"/> Diabetes (insulin, medication) _____ | <input type="checkbox"/> Parkinson's Disease                   |
| <input type="checkbox"/> Difficulty Breathing                 | <input type="checkbox"/> Psychiatric Problems _____            |
| <input type="checkbox"/> Difficulty sleeping                  | <input type="checkbox"/> Severe Headaches                      |
| <input type="checkbox"/> Dislocated/Swollen Joints _____      | <input type="checkbox"/> Shingles/ Skin disease _____          |
| <input type="checkbox"/> Drug/Alcohol Abuse                   | <input type="checkbox"/> Sinus Problems                        |
| <input type="checkbox"/> Eating Disorder                      | <input type="checkbox"/> Spinal Cord Injury _____              |
| <input type="checkbox"/> Emphysema or other Lung Disease      | <input type="checkbox"/> Stroke _____                          |
| <input type="checkbox"/> Epilepsy/Seizures                    | <input type="checkbox"/> Thyroid condition                     |
| <input type="checkbox"/> Fainting Spells/ Dizziness           | <input type="checkbox"/> Tuberculosis                          |
| <input type="checkbox"/> Fever Blisters                       | <input type="checkbox"/> Ulcers                                |
| <input type="checkbox"/> Fibromyalgia                         | <input type="checkbox"/> Venereal Disease                      |

Have you had a massage before? Yes No If yes, what type(s)? \_\_\_\_\_

\_\_\_\_\_

Do you have any areas that cause you chronic pain? Yes No If yes please circle the areas.



By signing this form, I understand that in New York State, to receive a massage, my medical history has to be given and it will be on file for the next 7 years. I understand the above information is necessary to provide me with effective therapeutic care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. I understand it is my responsibility to tell the therapist if anything changes in my medical history. I give my consent to be treated.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_