

REGISTRATION FORM

PATIENT INFORMATION

Patient's Last Name		First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital Status		<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	Social Security #			Home Phone No. ()				
Referral Physician <input type="checkbox"/> Dr. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.		Doctor's Phone No. ()		Doctor's Fax No. ()		Cell Phone No. ()						
Doctor's Address		City	State	ZIP Code	Work Phone No. ()							
Primary Care Physician (if different from referral source) <input type="checkbox"/> Dr.		Doctor's Phone No. ()		Doctor's Fax No. ()								
Doctor's Address		City	State	ZIP Code	E-mail address							

INSURANCE INFORMATION

(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST TO COPY)

Patient's Relationship to Subscriber		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Partner	<input type="checkbox"/> Other				
Subscriber (if not patient)	Birth Date	Address (if different)			Home Phone No. ()					
Is this person a patient here?		<input type="checkbox"/> Yes	<input type="checkbox"/> No							
Policy #		Primary insurance			<input type="checkbox"/> Aetna	<input type="checkbox"/> Blue Cross HMO	<input type="checkbox"/> BCBS	<input type="checkbox"/> Cigna	<input type="checkbox"/> MVP	<input type="checkbox"/> UHC
<input type="checkbox"/> Worker's Comp (specify company)		<input type="checkbox"/> Motor Vehicle (specify company)			<input type="checkbox"/> Other					
WC or NF Street Address		City		State	ZIP Code					
WC / NF caseworker name	Caseworker's phone #	Extension	claim #	Date of injury						
Occupation	Employer	Employer Address			Work phone ()					
Person authorized to schedule appointments for you					Phone #					
Person authorized to discuss billing for you					Phone #					

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

Clinic policies

- If you are running 10 or more minutes late for your appointment, we may have you reschedule so as not to put the therapist behind in their schedule.
- 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 missed appointments or cancellations with less than 24 hours notification, we will no longer schedule your appointments in advance. You may call on the day you would like to be seen to inquire if any appointments are available.
- **If your insurance requires referrals, we need to be sure that one is in place prior to your visit. Our office can get them set up for you if your doctor has not already done so. When your referral runs out, you may be liable for full payment if your insurance company denies the visit.**
- There will be a \$5 charge for any bill that needs to be mailed to you for payment on your account, so please stop at the desk to take care of your co-pays when you arrive at the office.
- If you are not sure of your co-pay amount, we will charge \$20 at the time of service and adjust after insurance remittance.
- Our office phone is not for personal use, so please do not ask our personnel if you may make a call.
- We ask that you not talk on your cell phones in the waiting area as it disturbs other patients and makes it difficult for our personnel to communicate with patients in the waiting area.
- Please do not wear perfume/cologne to your visit. Many of our patients and staff have sensitivities to strong scents.

Thank you for helping us to keep things running smoothly.

Patient 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. I understand that my health insurance may not pay for bandages, tape, ionto patches, tubing, Theraband, or other items necessary for my treatment because the items/service may not be a covered benefit under my insurance policy. I understand that if the cost of this service is not paid (in full or at all) by my insurance, that I will be responsible for the cost. I hereby agree to pay Callan-Harris Physical Therapy for the cost of the item or service if it is not covered by my insurance.

I understand that filing a claim with my insurance company does NOT relieve me from my responsibility for the payment of all charges.

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.

All co-payments are due at time of service and 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

INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

Name of insurance company(ies)

and assign directly to Callan-Harris Physical Therapy, P.C. all insurance benefits, if any, otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges incurred whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I understand that there may be a limit to the number of visits my insurance allows and will pay the hourly rate per visit when exceeding that limit.

The above-named practice may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed.

Initial _____

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 |

Please list any other medical condition(s) you have ever had: _____

Please list any drug, latex, food, or other allergies not previously mentioned? _____

Please list any surgeries you have had. _____

How do you spend your day now: _____

What would you like to do that you cannot now: _____

List 1-2 things you want therapy to do for you: _____

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.

Patient's Signature: _____ Date: _____