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1. Patient Registration: Demographic Information

Today's Date _____ Date of Appointment _____ First Name _____

Middle Initial _____ Last Name _____ Gender ☐ Female ☐ Male

Street Address _____ City _____ State _____

Zip _____ Home Phone: _____ Mobile Phone: _____

Email Address: _____ Preferred mode of communication: ○ Home Phone ○ Mobile Phone ○ Email Address

May we leave a message? ○ Yes ○ No

Employer _____

Birthdate _____

2. Are you a minor?

○ Yes
○ No

3. If a minor:

Legal Guardian Name _____ Phone Number _____

Relationship _____

Insurance Subscriber Date of Birth _____

4. Patient Registration: How Did You Hear About Us?

How did you learn about Prevail PT?
☐ Health Care Provider ☐ Internet Search
☐ Insurance Listing ☐ Personal Relationship
☐ Prior Patient ☐ Other

Elaborate (Name) : _____

5. Emergency Contact

Name: Relationship:

Telephone #: Alt. Phone:

Insurance Information

Signing this form confirms my authorization to disclose protected health information for medical purpose.

6. **Insurance Information: Referring Provider Information**

Referring Physician Phone:

Primary Care Physician Phone:

7. **Do you have a prescription for Physical Therapy? If so, you will be given an option to upload**

- ○ Yes
- ○ No: Insurance Doesn't Require
- ○ No: Need to Get

8. **Option: Upload your prescription as a PDF. This helps save considerable paper and time!**

9. **Will you be using your medical Insurance?**

- ○ Yes
- ○ No: Cash Pay
- ○ No: Worker's Comp
- ○ No: Auto Claim

10. **Primary Insurance: Information can be found on your insurance EOB (explanation of benefits)**

Primary Insurance Company: Subscriber Name:

Group #: ID #:

Yearly Deductible Co-Pay Amount

Visits Allowed For PT Coinsurance

11. **Option: Upload picture of ID and insurance card (Both sides)**

12. **Secondary Insurance:**

Secondary Insurance Company: Subscriber Name:

Group #: ID #:

13. **Workers Comp/Auto/Accident**

Workers' Compensation Carrier: _____ Claim #: _____ Date of Injury _____

Adjuster Name _____ Phone Number _____ Fax Number _____

Attorney Name _____ Phone Number _____ Fax Number _____

14. **Is your insurance through your job?**

- ○ Yes
- ○ No

15. **Are you currently or have you recently received Home Health Services?**

- ○ Yes
- ○ No

16. **If yes,**

☐ Still Receiving Treatment ☐ Discharged

Discharge Date

_____

17. **Health Status: What concern brings you in today?**

Patient Narrative

_____

_____

18. **How did your injury occur? Please check all that apply**

☐ Fall	☐ Sports Related	☐ Chronic
☐ Accident	☐ Motor Vehicle Accident Related	☐ Work Related
☐ Gradually	☐ Surgery Related	☐ Other

Narrative:

_____

19. **Date of Onset/Injury: If unknown, provide best estimate.**

Date of Onset

_____

20. **Have you had surgery for this condition?**

- ○ Yes
- ○ No

21. **If yes, please describe surgery:**

	Surgery	Date	Body Part
1			
2			
3			

22. Do you have pain?

- ○ Yes
- ○ No

23. Describe the type of pain you experience (check all that apply)

- ☐ Sharp?
- ☐ Dull?
- ☐ Shooting?
- ☐ Burning?
- ☐ Stabbing?
- ☐ Tingling?
- ☐ Intermittent?
- ☐ Constant?
- ☐ Deep?
- ☐ Superficial?
- ☐ Numb?
- ☐ Other?

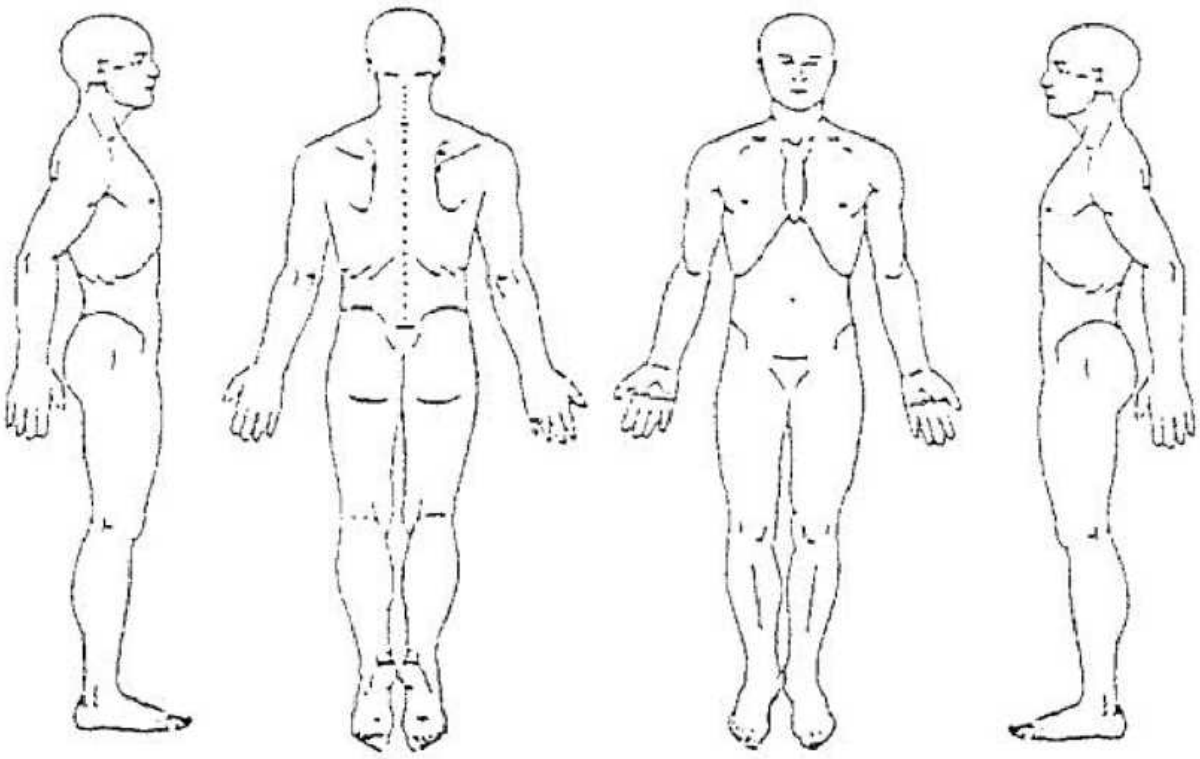
If other, specify:

_____

24. How severe is your pain: 0= no pain, 10= worst possible pain

At Best _____ At Worst _____ Currently _____

25. Indicate on the chart below the location(s) of the problem:



26. Have you had any diagnostic tests or imaging for this condition?

- ○ Yes
- ○ No

27. **Check all that apply:**

- ☐ MRI
- ☐ CT Scan
- ☐ X-ray
- ☐ EMG
- ☐ Other
- ☐ Nerve Conduction
- ☐ Ultrasound Imaging
- ☐ Lab Tests

28. **What were the results of diagnostic tests or images?**

Results

_____

_____

29. **Do you have any results from the imaging or testing to upload?**

30. **Have you been treated for this problem before?**

- ○ Yes
- ○ No

31. **If yes, have you been treated with:**

- ☐ Physical Therapy
- ☐ Massage
- ☐ Chiropractor
- ☐ Exercise
- ☐ Pilates
- ☐ Trigger Point Injection
- ☐ Medication
- ☐ Surgery
- ☐ Other

If other, specify:

_____

32. **Did this help?**

- ○ Yes
- ○ No

33. **What goal(s) do you have for your physical therapy sessions? Check all that apply**

- ☐ Decrease Pain
- ☐ Increase Function
- ☐ Improve Strength
- ☐ Learn Further Injury Prevention
- ☐ Improve Performance
- ☐ Decrease Fall Risk
- ☐ Return to Sport
- ☐ Return to Work
- ☐ Return to Daily Activities

34. **Medical and Health History: How would you rate your physical health?**

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

35. **Please answer the following questions:**

	Yes	No

Do your symptoms interrupt your sleep?		
Do you experience dizziness/lightheadedness?		
Have you had any falls over the past year?		
Do you have problems with coordination?		
Do you have blurred vision or other vision changes?		
Do you have a hearing impairment?		
Have you had a sudden change in bladder/bowel habits?		
Have you had a recent change in weight or appetite?		
Do you have any heat or cold intolerance?		
Do you have nausea/vomiting?		
Do you have bruising or bleeding problems?		
Do you use assist devices for mobility (i.e walker, orthotics, cane)?		
Do you have shortness of breath or decrease in exercise tolerance?		
Do you have osteoporosis/osteopenia?		
Do you have any implanted devices?		
Do you have a history of seizures?		
Do you have recurrent headaches?		
Do you have high blood pressure?		
Do you have any heart problems?		
Do you have diabetes?		
Are you (or could you be) pregnant?		
History of Anxiety/Depression?		
Other?		

36. Other Conditions

	Medical Conditions/injury
1	
2	
3	

37. Current Medications (If none, write "none" in the first space)

	Medication	Dose	Purpose
1			
2			
3			
4			

5			

38. Do you have any allergies?

- ○ Yes
- ○ No

39. If yes, describe

_____

40. Daily Activities: Are you currently employed?

- ○ Yes
- ○ No
- ○ At Home

41. Occupation:

_____

42. Describe the demands of your occupation

☐ Seated computer work ☐ Standing longer than 1 hour ☐ Light walking ☐ Heavy walking
☐ Lifting more than 10# ☐ Lifting more than 30# ☐ Carrying ☐ Overhead work ☐ Driving
☐ Heavy Machinery ☐ Kneeling/Squatting ☐ Repetitive Movement/Twisting ☐ Writing ☐ Climbing
☐ Pushing/Pulling

Can you perform the requirements of your occupation?
☐ Not at all ☐ Partially (25%) ☐ Half (50%) ☐ Mostly (75%) ☐ Yes

Please elaborate:

_____

_____

43. Overall Activity level prior to injury

- ○ Sedentary
- ○ Light
- ○ Moderate
- ○ Active
- ○ Extremely Active

44. Please indicate the type and duration of exercise/sports/recreation:

	Activity	Miles Per Week	Hours Per Week	Can Participate?
1				
2				
3				
4				

Late Notice Policy Section 1: I agree to pay $50 for appointments that I missed or cancelled with less than 24 hours notice. Notice means: sending an email, a phone call, or leaving a voicemail during business hours (Initial)

_____

Signature

Consent To Treatment Section 2: I hereby authorize the professional staff at Prevail Physical Therapy to examine and treat me with physical therapy for the injury I have referred here for or referred myself to. (Initial)

_____ _____

Signature Date

HIPAA Regulations Section 3: I understand that Prevail Physical Therapy complies with HIPAA and will protect my Protected Health Information (PHI). I understand my information will be used as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed, and full payment is received. I also authorize the release of any information pertinent to my case to my insurance company, adjuster, attorney, or medical provider for purpose of securing payment. This authorization remains in effect until 90 days from the date of the last bill collected. (Initial)

_____

Signature

Agreement for Direct Payment to Health Provider Section 4: Insurance Company/Companies: I hereby instruct the above-named insurance company/companies to pay Prevail Physical Therapy for professional or medical expenses allowable and otherwise payable to me under my current insurance policy. 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. (Initials)

_____

Signature

Responsibility of Payment Section 5: It is the policy of Prevail Practices, PLLC (DBA Prevail Physical Therapy) to bill your primary (and secondary if applicable) insurance policies for you. Our services are typically covered by most health insurance policies. However, there are variances in benefits among insurance companies and among policies, and not all services will always be covered by every company. We will attempt to verify your insurance and explain your Physical Therapy benefits to you. We will also notify you of required payments as they apply. Copayments will be due at the time of each visit, and coinsurance charges will be billed to you after payment, or explanation of payment, has been made by your insurance company. Should prior authorization/referral be required by your insurance provider, it is ultimately your responsibility to ensure that the process has been initiated and completed. Any fees not covered by your insurance are your responsibility. By initialing below, I hereby authorize my insurance company to pay directly to Prevail Practices, PLLC, the amounts due for services rendered to me or to my dependent. I authorize the release of my medical records as needed to process my insurance claim, as well as with other healthcare providers if needed to allow better collaboration between providers. I understand that I am responsible for all unpaid charges owed to Prevail Physical Therapy for services rendered and/or equipment purchased. The benefits quoted to you by Prevail are not a guarantee of benefits. Our clinic provides a summary of them when we can, as a courtesy to the patient. We encourage you to call your insurance company to verify your specific outpatient physical therapy benefits. (Initial)

_____

Signature

Signature and Date: I have read and understood Sections 1-5 and by initialing, I have agreed to Sections 1-5.
Full Signature: Parent/Guardian if under 18:

_____ _____

Signature Date