Initial Eval: _____

PATIENT REGISTRATION

Patient Information

Patient Full Name:_____ SS#/DL#:_____

Mailing Address:_____ City/State/Zip:_____

Home Phone #:_____ Cell Phone #:_____Age:_____ Birth Date:_____

Would you like to receive an automatic appointment reminder? If yes, Circle One: **Email / Text**

Email address: _____ **Cell Carrier**: _____ Martial Status: S M D W

Patient Employer: _____ Currently Working: _____ Work Phone #:_____

Emergency Contact Name, Relationship, & Phone #:_____

Reason for Therapy

Problem Description: _____ Onset Date/Accident Date/Surgery Date:_____

Referring Doctor & Phone #: _____ Primary Care Physician & Phone #: _____

Was this an injury at work? Y/N If Yes, **Name/Phone # of Case Manager**: _____/_____

Auto Accident? Y/N If yes, what state: _____ Other Accident in which someone else is at fault? Y/N

Will you be seeking reimbursement for your out of pocket expenses from a third party? Y/N

Insurance Information / Please bring your insurance card(s) to your first appointment.

Primary Insurance Company:_____ Policy #: _____
Secondary Insurance Company: _____ Policy #: _____

If insurance is in spouse or parent name, please provide the following:

Policyholder Name:_____ Policyholder Date of Birth: _____

Relationship to Patient: _____ Policyholder SSN: _____

Medicare Patients: Medicare has limited your outpatient therapy to $_____ per calendar year.
Have you received physical, speech, or occupational therapy services this year? _____
Are you currently receiving (or recently completed) any home health care? _____

If patient is a minor, please provide the following responsible party information:

Responsible Party Name: _____Date of Birth: _____Phone#: _____

Relationship to Patient: _____ Address: _____

MEDICAL INFORMATION

Patient Name:_____ Next Doctor's Appt:_____

Diagnosis:_____ Onset/Accident/Surgery Date:_____

Are you diabetic? _____ Yes _____ No If yes, do you take insulin? _____ Yes _____ No

Have you ever had surgery? _____ Yes _____ No

If yes, please list_____

_____

Do you suffer from dizziness, fainting, seizures, or convulsions? _____ Yes _____ No

If yes, please explain_____

Do you have high blood pressure? _____ Yes _____ No

If yes , please explain_____

Do you have a heart condition? _____ Yes _____ No Please list: _____

Do you have a pacemaker? _____ Yes _____ No

Have you ever had a blood clot or phlebitis? _____ Yes _____ No

If yes, where and when _____

Are you currently or have you in the past received treatment for cancer? _____ Yes _____ No

If yes, when_____

Do you have any other health problems? _____ Yes _____ No

If yes, please describe_____

Are you or could you be pregnant? _____ Yes _____ No

Patient or Legal Guardian Signature: _____ Date: _____

Patient Name _____

Date _____

Current Medications List (Prescription, non-prescription, vitamins, herbals)

Medication	Dosage	Frequency	Reason

Known Medication Allergies:

Patient Name: _____

STEWART PHYSICAL THERAPY CONSENT FORM

CONSENT TO TREAT

I hereby consent to evaluation and/or treatment of my condition by a licensed physical or occupational therapist employed by or under contract with Stewart Physical Therapy. I understand that I will be informed of the nature and purpose of the procedures, evaluation and plan of treatment. I will also be informed of the expected benefits and possible complications or discomfort, which may result from skilled physical therapy care.

I understand that there is not a guarantee that the proposed course of treatment will improve my condition and that it is possible, although unlikely, that the course of treatment may cause additional pain/discomfort or aggravate my condition. I have been given the opportunity to discuss my condition with the treating physical therapist. I consent and authorize Stewart Physical Therapy Clinics, Inc (including students in training) to administer treatment under the direction and supervision of the physical or occupational therapist.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize Stewart Physical Therapy to release medical information necessary to process insurance claim(s) on my behalf for services rendered. I request payment of any medical insurance, auto insurance, or liability proceeds or settlements to be made directly to Stewart Physical Therapy. I understand that I am responsible for any balance remaining after insurance or settlement from all sources. I agree to pay any remaining balance within 30 days. If I fail to pay any remaining balance due, Stewart Physical Therapy will have the right, to the extent allowed by law, to be paid back by me for all costs and expenses incurred in collecting sums due and in enforcing my agreement to pay, including but not limited to, reasonable attorneys fees.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION NOTICE OF PRIVACY PRACTICES

I have read the Stewart Physical Therapy Patient Consent for Use and Disclosure of Protected Health Information/Notice of Privacy Practices. I acknowledge receiving a copy and understand that at any time I may ask questions concerning my privacy rights and how Stewart Physical Therapy may use and disclose my protected health information.

ACKNOWLEDGMENT OF RECEIPT OF FINANCIAL POLICY

I have read and received a copy of the Financial Policy and understand Stewart Physical Therapy has not guaranteed payment by my insurance company only quoted what was relayed to them by my insurance company. In addition, I understand that any check received may be deposited electronically and a $30 fee will be added to my bill for any returned check.

CANCELLATION/NO SHOW

During your evaluation, you and your therapist will establish goals for your recovery. These goals are based on your participation in your therapy appointments. If you must cancel your scheduled appointment, we request a 24 hour notice. We reserve the right to charge you a $25 cancellation/no show fee if you habitually cancel or no show to your scheduled appointments.

_____

Patient/Legal Guardian Signature **Date**

Patient Consent for Use and Disclosure of Protected Health Information
Notice of Privacy Practices
Patient Copy

With my consent, Stewart Physical Therapy Clinics, Inc. may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations. Please refer to Stewart Physical Therapy Clinics, Inc. Notice of Privacy Practices for more complete description of such disclosures.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Stewart Physical Therapy Clinics, Inc. may decline to provide treatment to me.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Stewart Physical Therapy Clinics, Inc. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Stewart Physical Therapy Clinics, Inc.

With my consent, Stewart Physical Therapy Clinics, Inc. may call my home or other designated locations and leave a message on my voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any call pertaining to my care.

With my consent, Stewart Physical Therapy Clinics, Inc. may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as patient statements as long as they are marked Personal and Confidential.

With my consent, Stewart Physical Therapy Clinics, Inc. may email to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders and patient statements. I have the right to request Stewart Physical Therapy Clinics, Inc. restrict how it uses or discloses my protected health information to carry out treatment, payment and healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing the Stewart Physical Therapy Consent Form, I am consenting to Stewart Physical Therapy Clinics, Inc. use and disclose of my protected health information to carry out treatment, payment and healthcare operations.

I understand that Stewart Physical Therapy Clinics, Inc. will file my insurance and that I will be responsible for any copay, deductibles, coinsurance, or non-covered services. I assign payment directly to Stewart Physical Therapy Clinics, Inc. for the purpose of satisfying my account, but payment is not to exceed the regular charges. It is further agreed that any credit balance resulting from payment of the insurance or other sources may be applied to any other account owed to the practice by the insurance of his/her family. If I have questions or decide otherwise I will contact Stewart Physical Therapy Clinics, Inc.