

Maryland Physical Therapy
Patient Registration Form

** Please be sure to fill out all forms **COMPLETELY** before returning to front desk

Patient Name _____ Date of Birth _____ Sex _____
Address _____ Social Security Number _____
City, State _____ Zip _____ Home Phone _____
Employer _____ Work Phone _____
Cell Phone _____ E-mail _____
Emergency Contact _____ Emergency Phone _____
Referring Physician _____ Doctor's Phone _____
Primary Care Physician _____ PCP Phone _____

How did you hear about us? (Please check below)

Physician ___ Insurance ___ Self ___ Website ___ Friend/Family (name): _____

Have you had prior therapy? No Yes For which condition? _____

Marital Status: Single ___ Married ___ Divorced ___ Widowed ___

Employment Status: Full Time ___ Part Time ___ Unemployed ___ Retired ___

Is the problem related to a motor vehicle accident? No Yes

Is the problem related to a work injury? No Yes

Is the problem related to any other accident/injury? No Yes _____

Date of Onset/Injury/Accident _____

If you answered yes to either of the above, please complete the following:

REQUIRED INSURANCE INFORMATION

PIP or Worker's Compensation Carrier _____ Phone _____

Adjustor's Name _____ Claim Number _____

Claims address _____ City, State, Zip _____

Attorney name _____ Phone _____

REQUIRED HEALTH INSURANCE INFORMATION

Primary Insurance _____ Member Number _____

Relationship: Self Spouse Parent Other

Secondary Insurance _____ Member Number _____

Relationship: Self Spouse Parent Other

Information on Insurance Policy Holder (If other than self)

Last Name _____ First Name _____ MI _____

Social Security Number _____ Date of Birth ___/___/_____

Address _____ City/State/Zip _____

Home Telephone _____

Maryland Physical Therapy Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for *Maryland Physical Therapy* to furnish medical care and treatment to _____ considered necessary and proper in diagnosing or treating his/her physical condition.

Patient/Guardian _____ Date ___/___/___

Benefit Assignment/Release of Information

I hereby assign all medical benefits to which I am entitled, including private insurance and any other health plans, to *Maryland Physical Therapy*. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

Patient/Guardian _____ Date ___/___/___

Scheduling and Cancellation Policy

Maryland Physical Therapy reserves the right to bill a \$25 no show fee if we are not notified that you are unable to attend your scheduled appointment. If you cannot make your scheduled appointment time, we ask that you notify us as early as possible so that we may accommodate other patients. Consistency in treatment is important to your rehabilitation outcome, therefore multiple cancellations may result in termination of your treatment or a loss of prime (desired) schedule time.

Patient/Guardian _____ Date ___/___/___

Financial Policy Statement

It is our policy to bill your insurance carrier as a courtesy to you, although you are responsible for the entire bill when the services are rendered. A co-payment, if required by your health insurance carrier, will be due at the time of service. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. If any funds are paid in excess by your carrier, you will be promptly refunded the credit.

Patient/Guardian _____ Date ___/___/___

Acknowledgment of Receipt of Notice of Privacy Practices

I, _____, have received the Notice of Privacy Practices from Maryland Physical Therapy. The notice is dated April 14, 2003.

Date: _____

In lieu of patient signature, I, _____, a staff member of *Maryland Physical Therapy*, state that _____ has been given our current Notice of Privacy Practices. Date: ___/___/___

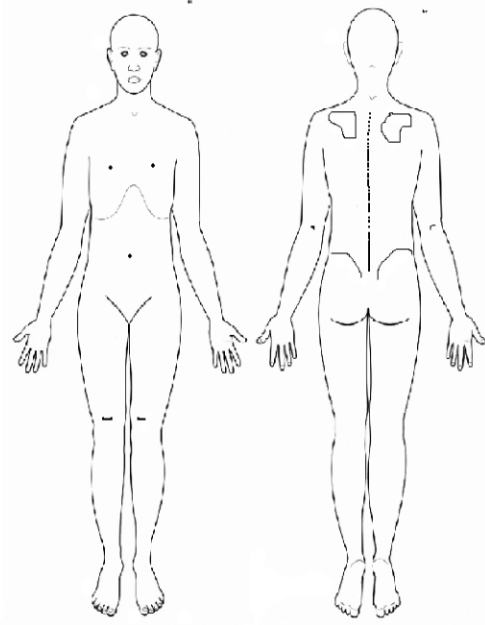
Circle a number indicating your current pain level

0 1 2 3 4 5 6 7 8 9 10

0= No Pain

10= Worse Possible

Circle if you have or have had the following:



AIDS	YES	NO
ALLERGIES	YES	NO
BREATHING PROBLEMS	YES	NO
CANCER	YES	NO
DENTAL PROBLEMS	YES	NO
DIABETES	YES	NO
DIZZINESS	YES	NO
HEADACHES	YES	NO
HEART/CIRC. DISEASE	YES	NO
OSTEOPENIA	YES	NO
OSTEOPOROSIS	YES	NO
PACEMAKER	YES	NO
PREGNANT NOW	YES	NO
RECENT WEIGHT LOSS	YES	NO
RHEUMATOID ARTHRITIS	YES	NO
SEIZURES	YES	NO
STEROID USE	YES	NO
SURGERIES	YES	NO
PREVIOUS TREATMENT FOR	YES	NO

Please mark the location of your pain on the drawing above and describe: _____

If you checked YES to any of the above questions please explain and give dates:

List current medications and state the condition that they are for:

CAN YOU PERFORM

	YES	NOT WELL		YES	NOT WELL
SITTING			STAIRS		
STANDING			DRESSING		
WALKING			PREPARING FOOD		
ROLLING			SQUATTING		
DRIVING			SHOPPING		
WALKING DISTANCE			LIFTING		
STOOPING			CARRYING		
MANAGING CHILDREN			REACHING		