THREE RIVERS
PHYSICAL THERAPY

Registration Form

Name: _____
Mr./Mrs./Ms. Last First Middle Initial

Address: _____

City: _____ State: _____ Zip: _____

Sex ☐ M ☐ F Age: _____ Birth date: _____Spouse's Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Social Security #: (optional) _____

Whom may we thank for referring you? _____

Referring Physician: _____ Primary Care Physician: _____

If you are a Medicare patient are you currently receiving home health services? ☐ Yes ☐ No

If Yes, which agency is providing those services: _____

Please complete this section if Workers' Compensation:

Insurance Name: _____ Claim #: _____

Employer: _____ Date of Injury: _____

Person to Contact at Employer: _____ Phone No. _____

Who is your Case Worker: _____ Phone No. _____

All new patients please complete the following section:

Primary Health Insurance Company: _____ Phone: _____

Policy Holder's Name: _____ Relation to Policy Holder:_____

Policy Holder's SSN: _____ Policy #: _____ Group #: _____

Policy Holder's DOB: _____ Policy Holder's Employer: _____

Secondary Health Insurance Company: _____ Phone: _____

Policy Holder's Name: _____ Relation to Policy Holder:_____

Policy Holder's SSN: _____ Policy #: _____ Group #: _____

Policy Holder's DOB: _____ Policy Holder's Employer: _____

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Symptom Sheet

Name_____ Date_____Age_____

Physician_____ Next Physician Appt._____

Occupation_____ Employer_____

Describe your problem_____
_____

Was this from an accident? Y N Date_____ If yes was it related to: Auto_____

On the job injury_____ Other_____

Have you had this problem before? Yes No

Have you had Physical Therapy for this problem before? Yes No

What time of day are your symptoms worse?_____ better_____

Do you have problems getting to sleep? Yes No Staying asleep? Yes No

Do you have any of the following symptoms? (circle all that apply)

Headaches	Weakness	Numbness	Tingling
Dizziness	Pain	Muscle Spasms	Decreased Motion

Other_____

Which of the following activities increases your symptoms? (circle all that apply)

Coughing	Sneezing	Swallowing	Lying on back
Bowel Movements	Urinating	Bending Forward	Lying on front

Other_____

Which of the following decreases your symptoms? (circle all that apply)

Heat Ice Massage Exercise

Have you had any diagnostic tests taken for this problem? (circle all that apply)

X-rays MRI CT Scan Bone Scan Nerve Conduction Other:_____

What medications are you taking for this problem:_____

Do you have any other medical conditions?_____

Are you taking any medications for these conditions?_____

Are you currently off work due to your Physical Therapy problem? Yes No

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INFORMED CONSENT

I consent to receiving physical therapy services which are deemed medically necessary by my referring and/or primary care physician. I authorize the release of medical information to my referring physician and insurance company.

I am aware that Three Rivers Physical Therapy will submit charges for services to my insurance company unless I make other arrangements. I hereby assign all medical benefits to be paid directly to Three Rivers Physical Therapy. I realize I am responsible for all charges incurred, regardless of payment by my insurance company. Any charges not paid by my insurance company will become my responsibility within 60 days. If it becomes necessary for my account to be assigned to a collection agency, I agree to pay all collection costs.

I assign any proceeds from any cause of action, whether from a court award or settlement, in the hands of my attorney, the responsible party, or the insurance carrier for the responsible party to Three Rivers Physical Therapy. I authorize and direct my attorney to pay all outstanding bills to Three Rivers Physical Therapy from the proceeds of any settlement.

I understand that there may be a twenty dollar ($ 20.00) handling fee for "no shows" and cancellations of more than 2 appointments without providing twenty-four (24) hour notice.

I authorize the use of this signature on all insurance submissions.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of Three Rivers Physical Therapy's **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I permit a copy of this authorization to be used in place of the original. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

Restriction(s): _____

_____

_____ _____

Patient or Representative Signature **Date**

If not signed by patient, please indicate relationship to patient (e.g., spouse, parent)

Relationship: _____