## Omnitherapy Center

# REGISTRATION FORM

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| (Please Print) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Today’s date: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Your EMAIL: | | | | | | | | | | | | | | | | | | | | | | | |
| PATIENT INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient’s last name: | | | | | | | | | | | | | | | | | | First: | | | | | | | | | | | | | Middle: | | | | | | ❑ Mr.  ❑ Mrs. | | | | ❑ Miss  ❑ Ms. | | | | | | | | Marital status (circle one) | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Single / Mar / Div / Sep / Wid | | | | | | | | | | | | |
| Is this your legal name? | | | | | | | If not, what is your legal name? | | | | | | | | | | | | | | | | | | | | | | (Former name): | | | | | | | | | | | | | | | Birth date: | | | | | | | | | | Age: | | | Sex: | | | | |
| ❑ Yes | | ❑ No | | | | |  | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | / / | | | | | | | | | |  | | | ❑ M | | | ❑ F | |
| Street address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Social Security no.: | | | | | | | | | | | | | | | | | Home phone no.: | | | | | | | | | | | | |
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| P.O. box: | | | | | | City: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | State: | | | | | | | | | | | | | ZIP Code: | | | | | | | | | |
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| Occupation: | | | | | | Current work status: \_Full time \_Part time | | | | | | | | | | | | | | | | | | | | | | | | | | | Employer’s name, address and phone #: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | \_Retired \_Disabled \_Homemaker \_Do not work | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Chose clinic because/Referred to clinic by (please check one box): | | | | | | | | | | | | | | | | | | | | | | | | | | | | ❑ Dr. | | | | |  | | | | | | | | | | | | | | | | | | ❑ Insurance Plan | | | | | | | | ❑ Hospital | | |
| ❑ Family | | | ❑ Friend | | | | | ❑ Close to home or work | | | | | | | | | | | | | | | | ❑ Internet search | | | | | | | | | | | | | | | ❑ Other | | | | | |  | | | | | | | | | | | | | | | | |
| Other family or friends seen here: | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| INSURANCE INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (Please give your insurance card to the receptionist.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Person responsible for bill: | | | | | | | | | Birth date: | | | | | | | | | | | | Address (if different): | | | | | | | | | | | | | | | | | | | | | | | | | | Home phone no.: | | | | | | | | | | | | | | |
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| Is this person a patient here? | | | | | | | | | ❑ Yes | | | | | | | ❑ No | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| Occupation: | | | | Employer’s Name: | | | | | | | | | | | | | | | | | | | Employer’s Address: | | | | | | | | | | | | | | | | | | | | | | | | Employer phone no.: | | | | | | | | | | | | | | |
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| Is this patient covered by insurance? | | | | | | | | | | | | | ❑ Yes | | | | | | | ❑ No | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please indicate primary insurance | | | | | | | | | | | ❑ Traditional Medicare | | | | | | | | | | | | | | ❑ BC/BS of NJ | | | | | | | | | ❑ UHC | | | | | | | | | | | | ❑ Cigna | | | | | | | | | ❑ Aetna | | | | | | |
| ❑ Oxford | | | | | ❑ Auto | | | | | | | | | | | | ❑ Clover | | | | | | | | | | ❑ Workers Comp. | | | | | | | | | | | | | | | | | | | ❑ Other: | | | | | | |  | | | | | | | | |
| Subscriber’s name: | | | | | | | | | | | Subscriber’s S.S. no.: | | | | | | | | | | | | | | | Birth date: | | | | | | | | | Group no.: | | | | | | | | | | | | | Policy no.: | | | | | | | | | | Co-payment: | | | |
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| Patient’s relationship to subscriber: | | | | | | | | | | | | | | ❑ Self | | | | | | | | ❑ Spouse | | | | | | | | ❑ Child | | | | | ❑ Other | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| Name of secondary insurance (if applicable): | | | | | | | | | | | | | | | | | | | Subscriber’s name: | | | | | | | | | | | | | | | | | | | | | | | Group no.: | | | | | | | | | | | | | | Policy no.: | | | | | |
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| Patient’s relationship to subscriber: | | | | | | | | | | | | | | | ❑ Self | | | | | | | ❑ Spouse | | | | | | | | ❑ Child | | | | | ❑ Other | | | | | | |  | | | | | | | | | | | | | | | | | | | |
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| What area(s) will we be treating: | | | | | | | | | | Have you had any physical therapy sessions in the past six months, at your house or elsewhere? | | | | | | | | | | | | | | | | | | | | | | | | | | Did you have surgery on this area, if so, when? | | | | | | | | | | | | | | Emergency Contact Information:  Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Tel. #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |
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| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Omnitherapy Center. I understand that I am financially responsible for any balance, co-insurance or co-pays. I also authorize Omnitherapy Center or any insurance company to release any information required to process my claims. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | Patient/Guardian signature: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | Date: | | | | | | | | | | | | | | | | | |  |

**Omnitherapy Center**

**PATIENT HEALTH HISTORY FORM**

**DATE OF INJURY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF SURGEY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CURRENT WEIGHT\_\_\_\_\_\_\_\_\_CURRENT HEIGHT\_\_\_\_\_\_\_\_\_\_**

**WHAT IS YOUR PRIMARY COMPLAINT THAT BRINGS YOU HERE?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PAIN LEVEL: 0 1 2 3 4 5 6 7 8 9 10 SEVERITY LEVEL: MILD MODERATE SEVERE**

**WHEN AND HOW DID YOUR SYMPTOMS BEGIN? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WHAT IS YOUR PRESENT CONDITION STOPPING YOU FROM DOING?:**

1. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WAS ANY TESTING PERFORMED, XRAY, MRI, EMG, ETC? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HAVE YOU FALLEN WITHIN THE LAST YEAR?: \_\_YES \_\_NO IF YES, HOW MANY TIMES:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HAVE YOU RECEIVED TREATMENT FOR THIS CONDITION BEFORE? YES\_\_\_ NO\_\_\_\_**

**IF YES, PLEASE EXPLAIN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ARE YOU PREGNANT? YES\_\_ NO\_\_ N/A\_\_ IF YES, HOW MANY MONTHS?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICAL HISTORY: CHECK ALL THAT APPLY**

**Neuro**

* **Dizziness**
* **Fainting**
* **Seizures**
* **Vertigo**
* **Balance Problems**
* **Stroke**
* **Headaches**

**Skin**

* **Skin Allergies/Disease**
* **Shingles**
* **Cellulitis**
* **Wound(s)**

**Other:**

* **Hernia**
* **Thyroid Condition**
* **Cancer**
* **Weight Loss Surgery**

**Psychological**

* **Depression/Anxiety**
* **Other:\_\_\_\_\_\_\_\_\_\_\_\_**

**Kidney/Pancreas**

* **Diabetes**
* **Kidney Disease**
* **Dialysis**

**Respiratory**

* **Asthma**
* **Shortness of Breath**
* **Tuberculosis**
* **COPD/Emphysema**

**Joints**

* **Arthritis**
* **Back condition**
* **Previous surgery**
* **Metal Implant**
* **Injections/epidurals**

**Cardiac**

* **Pacemaker/defibrillator**
* **Chest Pain/Pressure**
* **High/Low Blood Pressure**
* **History of Heart Attack**
* **Mitral Valve Collapse**
* **A Fib**
* **Coronary Artery Disease**
* **Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Blood Pathogens**

* **MRSA HIV/AIDS**
* **Hepatitis**
* **Blood Transfusion**

**Sensory**

* **Speech Impairment**
* **Vision Impairment**
* **Hearing Impairment**

**PRIOR SURGERIES OR ANY OTHER MEDICAL CONDITIONS NOT LISTED ABOVE:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WHAT IS THE MAIN GOAL YOU WANT TO ACCOMPLISH WITH THE PHYSICAL THERAPIST?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Omnitherapy Center**

**MEDICATION LIST**

|  |  |  |  |
| --- | --- | --- | --- |
| MEDICATION: | DOSAGE OR AMOUNT: | FORM TAKEN (PILL, INJECTION): | FREQUENCY TAKEN: |
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### Omnitherapy Center

CONSENT FORM

**Authorization for release of Medical Information:**

I authorize Omnitherapy Center to release all information necessary to verify insurance benefits and/or process my insurance claims to my insurance carrier9s0 for payment of services rendered to me including the release of any pertinent information to any case worker, adjuster or employer involved in this case. I authorize the release of my medical records if needed to Omnitherapy Center by all my healthcare providers in order to coordinate my care.

**INITIAL**

**Authorization for Treatment:**

By signing this form, I am requesting and consenting to the evaluative and therapeutic procedures which may include, but are not limited to physical examination and physical therapy treatment. I hereby warrant that I have not been adjudged as incompetent. I understand that it is my right to determine the extent of my medical care, and that I may, at any time, refuse treatment and withdraw my consent for the performance of any procedure or treatment. I recognize that no guarantees have been or can be made regarding the likelihood of success or the outcome of any evaluation, treatment, procedure or therapy performed.

**INITIAL**

**Assignment of Benefits/Cancellation Fee:**

I request that payment of authorized insurance benefits be made on my behalf directly to Omnitherapy Center and/or Ana Pozzoli, PT at the current address my services are rendered. If my current policy prohibits direct payment to the provider, I direct payment be mailed to me c/o Omnitherapy Center at the address my services are rendered. THIS IS A DIRECT ASSIGNMENT OF MY BENEFITS UNDER MY POLICY. I also authorize Omnitherapy Center, LLC and/or Ana Pozzoli, PT to initiate a complaint and/or appeal to my insurance carrier or to the Insurance Commissioner on my behalf.

This is an-individual-appointment-based-physical therapy establishment, and I understand that there is a **‘cancellation fee’** of **$45.00** if I do not show-up or cancel therapy without calling this office **24 hours** in advance.

**INITIAL**

**Notice of Privacy Practices:**

The notice of privacy practices is posted in the waiting room. If you would like a copy please inform our staff and we will be happy to provide you with a copy.

**INITIAL**

**FINANCIAL POLICY**

Please note that we participate in many different insurance plans and every policy is different; it is your responsibility to get referrals, know your visit limit and dollar amount limit. We will assist you in verifying your benefits, but it is your responsibility for your co-pays, your co-insurance, deductibles or any procedures not covered by your insurance.

I hereby authorize and guarantee payment for all services rendered.

Although fees for services are due and payment expected at the time services are rendered, unless I have been granted a grace period for payment of fees, I acknowledge that payment is due and expected at the time the billing statement is received.

In the event that my account becomes delinquent for more than 30 days, I also agree to pay a finance charge of 1.5% per month on any balance due, as well as all reasonable collection costs, court costs, attorney fees and interest accrued with the collection of this account.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sign (by the responsible party) Dated