515 Providence Highway, Lower 6 • Dedham, MA 02026
703-646-0313 phone • 617-553-4479 fax
karen@karentaylorsoilespt.com
Postural Restoration (PRI) Certified
www.karentaylorsoilespt.com

PATIENT REGISTRATION

Date ________________________________

Last Name ________________________ First ___________________________ Middle __________________

Date of Birth ____________________________

Address ____

City _______________________________________ State ___________________ Zip ___________________

Email address _____________________________________ Cell phone __________________________________

Referred by ____

Occupation ____

Emergency Contact______________________ Relation ___________________ Phone ___________________

Primary Care Provider ____

Address ____

Phone ____ Fax __________________________________

Referring Practitioner ____

Address ____

Phone ____ Fax __________________________________

Signature ____

MEDICAL HISTORY

Patient Name ____ Date ________________________

EXISTING OR RELEVANT PREVIOUS CONDITIONS – please check if applicable

Condition	
Allergies	○ Yes ○ No
Anemia	○ Yes ○ No
Anxiety	○ Yes ○ No
Arthritis	○ Yes ○ No
Asthma	○ Yes ○ No
Autoimmune Disorder	○ Yes ○ No
Cancer	○ Yes ○ No
Cardiac Conditions	○ Yes ○ No
Cardiac Pacemaker	○ Yes ○ No
Chemical Dependency	○ Yes ○ No
Circulation Problems	○ Yes ○ No
Currently Pregnant	○ Yes ○ No
Depression	○ Yes ○ No
Diabetes	○ Yes ○ No

Condition	
Dizzy Spells	○ Yes ○ No
Emphysema/Bronchitis	○ Yes ○ No
Fibromyalgia	○ Yes ○ No
Fractures	○ Yes ○ No
Gallbladder Problems	○ Yes ○ No
Headaches	○ Yes ○ No
Hearing Impairment	○ Yes ○ No
Hepatitis	○ Yes ○ No
High Cholesterol	○ Yes ○ No
High/Low Blood Pressure	○ Yes ○ No
HIV/AIDS	○ Yes ○ No
Incontinence	○ Yes ○ No
Kidney Problems	○ Yes ○ No
Metal Implants	○ Yes ○ No

Condition	
MRSA	○ Yes ○ No
Multiple Sclerosis	○ Yes ○ No
Muscular Disease	○ Yes ○ No
Osteoporosis	○ Yes ○ No
Parkinsons	○ Yes ○ No
Rheumatoid Arthritis	○ Yes ○ No
Seizures	○ Yes ○ No
Smoking	○ Yes ○ No
Speech Problems	○ Yes ○ No
Strokes	○ Yes ○ No
Thyroid Disease	○ Yes ○ No
Tuberculosis	○ Yes ○ No
Vision Problems	○ Yes ○ No

Please list any other conditions ____

CURRENT MEDICATIONS – list or attach copy

Medication Name	Dosage	Frequency	Purpose of Medication

SUPPLEMENTS

Supplement Name	Dosage	Frequency	Purpose of Supplement

SURGICAL HISTORY

Body Region	Surgery Type	Date

FALL HISTORY – please answer Yes or No

Is this injury a result of a fall in the past year? __________ Have you had 2 or more falls in the past year? __________

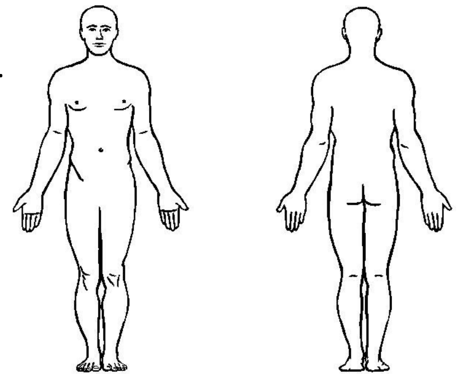
Do you feel at risk for falls? __________

DIETARY HABITS – please indicate what you typically consume within each category

Breakfast	
Lunch	
Dinner	
Snacks	
Beverages please include alcoholic, non-alcoholic and water	

On the pictures to the right, please indicate the location of your symptoms.

On the scale below, please indicate your level of discomfort at its worst and best.



0 1 2 3 4 5 6 7 8 9 10

0 = No discomfort 10 = Extreme discomfort

Please identify up to 3 activities that you are unable to do or are having difficulty with (i.e., getting dressed, walking your dog, yard work, sports, etc.).

Activity	Most Limited

Signature ____

PATIENT WAIVER AND FINANCIAL CONSENT

I voluntarily consent to physical therapy treatment for the below named client and services deemed necessary by my physical therapist and/or physician. I am aware that the practice of physical therapy is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of these services at Karen Taylor Soiles PT, LLC. It is this clinic's sincere intent to educate me on every process, from billing to treatment and eventually discharge from services. Therefore, if techniques being used to retrain, recruit and restore postural alignment are not understood, it is my responsibility to obtain a clearer understanding of what the therapist's objectives and outcomes are, and how she is trying to achieve them.

- I certify all the information provided is correct and true to the best of my knowledge
- I will be responsible for payment of services in full at each visit unless other definitive financial arrangements have been made prior to treatment.
- I understand that Karen Taylor Soiles PT, LLC is an out-of-network provider and does not accept or bill insurance. Karen Taylor Soiles PT, LLC will provide me documentation to submit to my insurance.
- I authorize the release of all medical records to my referring and/or primary care physician and to my insurance company, if applicable.
- I allow fax transmittal of my medical records, if necessary.
- I agree to pay all reasonable attorney fees and collection of costs in the event of default of payment of my charges.
- This consent is valid from one year from the date listed below.
- I permit a copy of this authorization to be used in place of original.
- I have read and fully understand the above consent for treatment, financial responsibly, release of medical information and insurance authorization.
- I hereby acknowledge I have access to this medical practice's *Notice of Privacy Practices* via website, display in office or provided upon request (Karen Taylor Soiles, Privacy Officer).

I have read and fully understand the above consent for treatment, financial responsibility, insurance guidelines and release of medical information.

Patient Name ____

Signature____ Date ___________________________________

PRACTICE POLICIES

New Patients: Please be sure to complete the registration forms BEFORE your appointment. Please bring your driver's license with you.

Prescription/Referral: If you have a prescription/referral from your doctor, please bring it with you. A referral is not required for first 30-day treatment period.

Fees/Payment: Payment in full is required at the time services are rendered. Checks are preferred, but cash and credit cards are accepted. Karen Taylor Soiles PT, LLC reserves the right to charge an additional $50 for each returned check.

Insurance: Karen Taylor Soiles PT, LLC is an out of network provider for all insurances and does not submit insurance claims. We will provide you with a receipt (with diagnosis and CPT codes and billed amounts) to submit to your insurance company. We strongly recommend you contact your insurance company before your first visit to be best informed about your coverage.

Treatment Sessions: Wear or bring clothes that allow for full movement (shorts, loose pants, t- shirt, sports bra, tank tops or camisoles are all good choices) Supportive footwear is a must.

Tardiness: We ask that you arrive on time for your appointments. If you arrive late, your treatment will be shortened, and you will be responsible for payment of the full visit.

Cancellation/No Show: Karen Taylor Soiles PT, LLC places a tremendous value on the time to work thoroughly and individually with each patient. For this reason, 24 hours' notice is required prior to your appointment if cancellation is necessary. Any missed appointments or cancellations with less than 24 hours' notice will result in a fee of $75.

I have reviewed and accept these policies.

Patient Name ____

Signature____________________________________ Date ____________________________