REGISTRATION FORM

Today's Date	**Primary Care Physician**

PATIENT INFORMATION

Patient's Last Name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital Status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

If under 18, name of parent/guardian:	Social Security no.:	Birth Date:	Age:	Sex: ☐ F ☐ M	Date of Injury:

Street Address:	Email Address:	Home Phone No.: ( )	Cell Phone No.: ( )

City:	State:	ZIP Code	Occupation:

Employer:	Work Status: FT ☐ PT ☐ Diem ☐ Disabled ☐ Retired ☐ Unemployed ☐ Other ___________________	Employer Phone No.: ( )

Referred by or choose this clinic because... (Please check one box):	☐ Dr.	☐ Insurance plan	☐ Hospital

☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ Other

Other family members seen here: Have you been previously treated here: No ☐ Yes ☐ when: ___________

INSURANCE INFORMATION

(Please give your insurance card and a picture ID to the receptionist.)

Name of Primary Insurance/Group no.:	Subscriber's Name:	Birth Date:	Home Phone No.: ( )

Occupation:	Employer:	Employer Address:	Employer Phone No.: ( )

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of Secondary Insurance (if applicable):	Subscriber's Name:	Group No.:	Policy No.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Motor Vehicle Accident: No ☐ Yes ☐ Date of accident:	**Work Related Injury**: No ☐ Yes ☐ Date of injury:

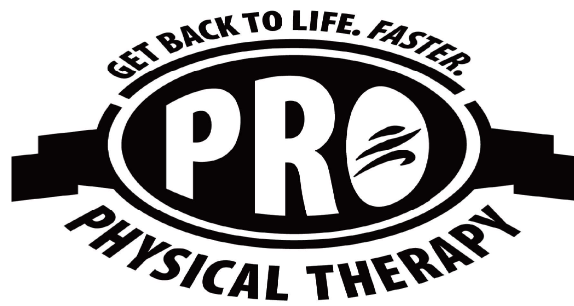
Attorney/Insurance Name:	Address:	Contact Phone No.: ( )

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to Patient:	Home Phone No.: ( )	Work Phone No.: ( )

The above information is true to the best of my knowledge. I consent to treatment and authorize my insurance benefits be paid directly to Nissenbaum and Schleusner PRO Physical Therapy, LLC. I understand that I am financially responsible for any balance. I also authorize Nissenbaum and Schleusner PRO Physical Therapy, LLC or the insurance company to release any information required in processing my claims.

Patient/ Guardian Signature *Date*



Attendance and Financial Policy

Please initial at the end of each paragraph where indicated

1. Attendance and Cancellation Policy:

In order to fully achieve your goals, consistent and regular appointments are key to your program. We do understand that things come up in life and you need to cancel. We ask that if you need to cancel, please give us 24-hour notice. Failure to do so may result in a $25 cancellation fee. If there are consistent attendance issues, PRO Physical Therapy does reserve the right to cancel future appointments. Please be on time. If you show up greater than 10 minutes late we may need to reschedule your appointment. _______

2. Payment Responsibility:

I acknowledge that I am financially responsible for my treatment and bill at PRO Physical Therapy. It is my responsibility to provide PRO Physical Therapy with my current insurance information. I also acknowledge that PRO Physical Therapy will assist in obtaining my benefit information but ultimately it is my responsibility to know my benefits. I also acknowledge that I am responsible for updating PRO Physical Therapy if my policy or insurance changes and I am responsible for any uncovered services if I fail to inform. I understand that PRO Physical Therapy will submit claims to my insurance carrier and I am responsible for any allowed patient responsibility after insurance payment and contractual adjustments. I am aware that not all services provided may be covered by my insurance, and any uncovered charges will be my responsibility. I acknowledge that I am required to pay my co-payment at the time of service. If my co-payment is not available at the time of service I agree pay at the next follow up visit or by phone within 3 business days. ______

3. Prompt Pay and membership discount:

At Pro Physical Therapy if you would rather not use your insurance or we don't take your insurance you can self pay or pay for one of our membership packages. In order to do prompt pay and offer a discount we have to have payment at the time of service. If you would like to have a credit card on file, we can certainly do that as well. Please let us know if you have any questions regarding this service.

Refund Policy for packages: If a package is not used after 6 months, a refund can be requested. Nissenbaum and Schleusner PRO Physical Therapy will charge a $50 service fee for processing the refund. However, no refunds will be given after 1 year from the date of purchase. If a refund is given you will not receive the package discount and will be charged full daily rate of $125 per visit prior to refund.

PATIENT UNDERSTANDS THAT INSURANCE WILL NOT BE BILLED AND THIS AMOUNT WILL NOT APPLY TO ANY DEDUCTIBLES OR OUT OF POCKET AMOUNTS REQUIRED BY YOUR INSURANCE COMPANY. ________

4. Worker's Compensation Claims (if applicable):

I agree to provide PRO Physical Therapy with my worker's compensation information as well as my personal health insurance. I understand that PRO Physical Therapy has nothing to do with my worker's compensation claim other than billing my worker's compensation insurance. In the event worker's compensation denies my claim, I understand PRO Physical Therapy will bill my personal health insurance (if in-network). If my insurance is not in-network with PRO Physical Therapy, I understand that if my worker's compensation claim is denied, I will be responsible for payment.

____

5. Past Due Accounts:

We ask that you pay your bills on time. If you are unable to pay your bill or your account becomes overdue, a 2% interest will be added monthly to your account over 30 days. If your account becomes overdue, it may be referred to a collection agency and/or attorney. We can certainly figure out payment plans as well. Please discuss payment plans with our office manager. This is to acknowledge that I understand what will occur if my account is past due. ________

6. Access and Release of Health Information:

I authorize PRO Physical Therapy to bill my insurance on my behalf. I authorize my Physical Therapist and those involved in my care to contact other health professionals that may have related information to my health care as deemed appropriate by my therapist. I have received PRO physical Therapy's notice of HIPAA privacy policy and understand how my health insurance may be used and disclosed and how I can gain access to my health information at PRO Physical Therapy. _______

7. Communication with PRO Physical Therapy/HIPAA Individual Authorization

I authorize the following means of communication with those involved in my care:

Voicemail: The PRO Physical Therapy team my leave a detailed voicemail or call me at:

Work_______________________ Cell__________________________ Home_________________________________

I authorize the following individuals to receive verbal or written information regarding my care or my account at PRO Physical Therapy:

_____________________________ Name/relationship __________________________Name/relationship

By signing below, I certify that I have read, understand, and fully agree to each of the statements in this document and have had the opportunity to discuss any questions that I have regarding information presented.

____ _____________________

Signature of Patient or Legally responsible person Date

____

Printed Name

If you have any billing or financial questions, please contact our Office Manager at (608) 841-1290

Nissenbaum and Schleusner PRO Physical Therapy LLC
Medical History Form

Name ____

Age________ Height_________ Weight_________ Sex: Male/Female/___________ Handedness: Right/Left/Ambidextrous

Occupation____

Work status: Full Time Part Time Not Working Medical Leave Retired Student

What are the problem(s) you are here for? If post surgery, list your type of surgery.

____

Symptoms are related to?
Work injury? Yes No
Motor Vehicle Accident? Yes No
Sports Injury? Yes No
Fall? Yes No
Overuse? Yes No
Surgery? Yes No

When and how did your symptoms/problems begin? List date if there was an event or surgery.

____

____

Are your symptoms: Getting Better Worse Same Come and Go

Prior to this episode or event did you have any limitations? Yes No

If yes, what are they?____

Does your current condition limit you in performing Household tasks/duties? Yes No

Does your current condition limit you in performing Job Related tasks/duties? Yes No

Are you currently off work because of this problem? Yes No Light duty

Have you had this problem before? Yes No

If yes, when and how did it get better?____

____

Any previous treatment for your current condition? Yes No

Physical Therapy Chiropractic Injection Surgical intervention Alternative Medicine Acupuncture

What tests have you had for this complaint? Dates?

X-ray ___________ MRI ___________ CT Scan ___________ Diagnostic US ___________

EMG/NCV__________ DXA __________ Other ____

What symptoms are you experiencing with this complaint? (Circle all that apply)

Swelling Stiffness Numbness Tingling Fatigue Loss of balance Pain

Weakness Instability Loss of Motion Other symptoms: ____________________________

What makes your symptoms worse? (please circle all that apply)

Sitting Standing Walking Lifting Bending Lying down Squatting Stress

Other____

What makes your symptoms better? (please circle all that apply)

Sitting Standing Walking Lifting Bending Lying down Squatting Stress

Other____

How do you sleep at night? No problem Toss and Turn Only with meds Fair

What time of day are your symptoms Worst? ___________ **Best?**____________

Pain CURRENTLY: Rate your pain at this time.

0 1 2 3 4 5 6 7 8 9 10

No pain Worst pain Imaginable

Pain at its BEST: If at any point you have no pain in the past 24 hrs, circle zero.

0 1 2 3 4 5 6 7 8 9 10

No pain Worst pain Imaginable

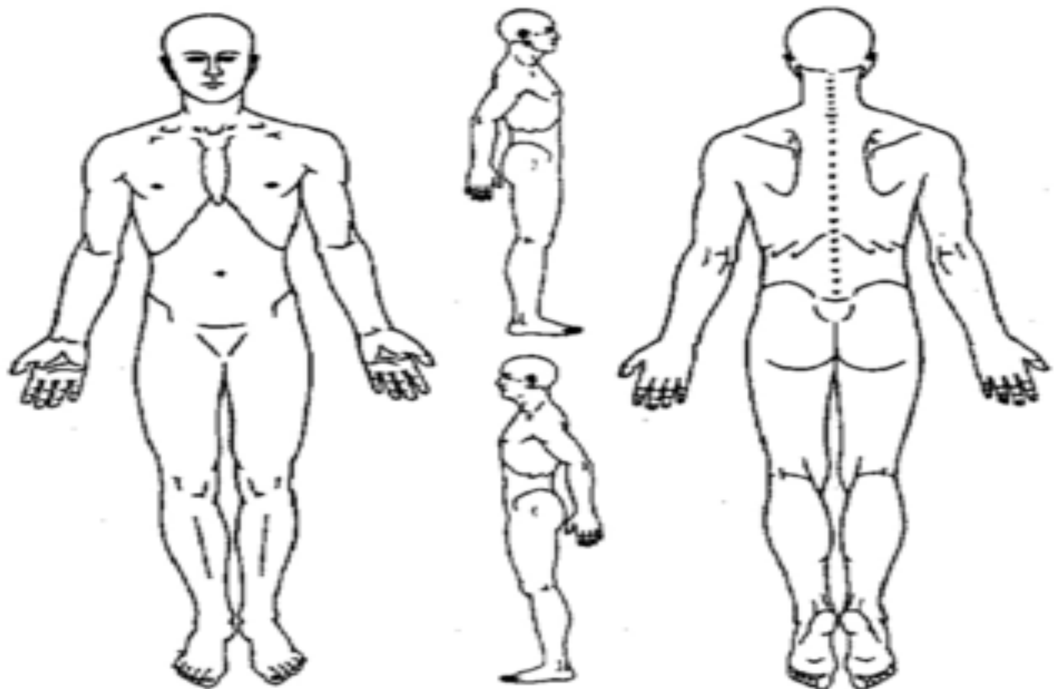
Pain at its WORST: Rate your highest pain level in the past 24 hrs.

0 1 2 3 4 5 6 7 8 9 10

No pain Worst pain Imaginable

Body Chart:
Please mark the location of your pain and type of pain on the chart:

Key:
- X Sharp Stabbing
- O Dull Achy
- …. Numb/Tingling
- //// Throbbing
- == Burning



What are your goals in physical therapy? ____

____

____

What is your general health? Excellent Good Fair Poor
Do you use tobacco? Yes No
Do you exercise regularly? Yes No

Please check if you OR any immediate family member (parent, sibling, child) have ever been told you/they have:

	Personal History	Family History		Personal History	Family History
Brain, Nerves	☐	☐	*Blood*	☐	☐
Alzheimer's Disease	☐	☐	Anemia	☐	☐
Epilepsy	☐	☐	Hemophilia (slow healing)	☐	☐
Herniated Disk	☐	☐	*Cancer*	☐	☐
Multiple Sclerosis	☐	☐	Cancer (list location)	☐	☐
Parkinson's Disease	☐	☐			
Peripheral Neuropathy (loss of sensation in the feet)	☐	☐	*Liver/Kidney*	☐	☐
			Cirrhosis/Liver Disease	☐	☐
Seizures	☐	☐	Kidney Disease/Stones	☐	☐
Stroke	☐	☐	*Musculoskeletal*	☐	☐
Cardiovascular	☐	☐	Arthritis (list location)	☐	☐
Angina/Chest Pain	☐	☐			
Blood Clot	☐	☐	Back Injury	☐	☐
Heart Attack	☐	☐	Carpal Tunnel Syndrome	☐	☐
High Blood Pressure	☐	☐	Degenerative Disk Disease	☐	☐
High Cholesterol	☐	☐	Fibromyalgia	☐	☐
Peripheral Vascular Disease	☐	☐	Fracture (list location)	☐	☐
Endocrine/Immune System	☐	☐			
Diabetes	☐	☐	Osteoporosis/Osteopenia	☐	☐
Hepatitis	☐	☐	*Psych*	☐	☐
Hyperthyroidism (High)	☐	☐	Anxiety/Panic Attacks	☐	☐
Hypothyroidism (Low)	☐	☐	Chemical Dependency	☐	☐
Lupus	☐	☐	Depression	☐	☐
Lungs	☐	☐	Eating Disorder	☐	☐
Asthma	☐	☐	Other Psychiatric Disorder:	☐	☐
Emphysema	☐	☐			
Sleep Apnea	☐	☐	*Other:*	☐	☐
Tuberculosis	☐	☐			

Any allergies? Yes No **Latex Allergy?** Yes No
If yes, please list:____
Past surgical history? Yes No
If yes, please explain:____
Any other orthopedic problems? Yes or No
If yes, please explain:____

Please list **ALL** medications you are currently taking such as prescription and over-the-counter for this and any other condition (You can bring in a list in you would rather) ______________________________________
____
____

Where do you currently live? House Apt/Condo Nursing Home
Do you live alone? Yes No
If you are over 65, how many falls have you had in the past 6 months? ____________________

Thanks for taking the time to fill out this form as completely as possible! It will save us on treatment time during your first visit and will help in assessing your condition and guiding your treatment plan.

Patient Signature ______________________________ Date ____________________

FOR CLINIC USE ONLY
PT Initials __________ Date ____________________