CHESTERTON PHYSICAL THERAPY, INC.
*Great Health Through Great Physical Therapy*

# Patient Registration

Are you a former patient? ☐ Yes ☐ No

First Name _____ Middle Name or Initial _____ Last Name _____

Mailing/Street Address _____

City _____ State _____ Zip Code _____

Cell Phone # _____ Home Phone # _____ Work Phone # _____

E-mail Address _____ Birthdate: mm/dd/yyyy _____

Marital Status: ☐ Married ☐ Single ☐ Other Sex: ○ Male ○ Female ○ Other

## Physician Information

Referring Physician Name: _____ Phone: _____

Primary Care Physician Name: _____ Phone: _____

## Insurance Information

Who is the Policy Holder? *(Please circle)* Self Spouse Parent Other

Primary Health Insurance Company _____ Secondary Health Insurance Company _____

Name of Policy Holder _____ Policy Holder's Date of Birth (mm/dd/yyyy) _____

Have you verified your therapy benefits with your insurance? ☐ Yes ☐ No
If not, we strongly encourage you to do so.

## Auto/3rd Party Auto Information

Date of Accident: _____ City/State: _____

Auto Insurance Company: _____ Claim # _____

Adjuster Name: _____ Phone # _____

Is this a lawsuit? Yes ☐ No ☐ Law Firm Name: _____

Attorney Name: _____ Attorney Phone: _____

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## INFORMED CONSENT AND STATEMENT OF FINANCIAL RESPONSIBILITY

**1.** **CONSENT FOR TREATMENT:** I consent to and authorize my physical therapist, occupational therapist, and other healthcare professionals and assistants who may be involved in my care, to provide care and treatment prescribed by and/or considered necessary or advisable by my physician(s)/health care provider(s). I acknowledge that no guarantees have been made to me about the results of treatment.

**2.** **NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT:** I have been given the opportunity to review Chesterton Physical Therapy's "Notice of Privacy Practices" which is displayed in the reception area. This notice of privacy practices provides information on the uses and disclosures of my protected health information. I understand that this notice is subject to change, and if changes are made, a revised copy of the notice will be posted in the reception area. I also understand that if I have any questions, I may contact the Privacy Officer at (219) 926-9779.

**3.** **RESPONSIBILITY FOR PAYMENT:** All co-payments are due at the time of service. I acknowledge that in consideration of the services provided to me by Chesterton Physical Therapy, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide Chesterton Physical Therapy with current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. My health insurance plan may provide that a portion of the charges and balance will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible.

***Please note that refusal to sign this form does not change responsibility for payment in any way.***

**4.** **ASSIGNMENT OF BENEFITS:** I hereby assign to Chesterton Physical Therapy all my rights and claims for reimbursement under my health insurance policy. I agree to provide information as needed to establish my eligibility for such benefits.

**5.** **ACCESS TO AND RELEASE OF HEALTH INFORMATION:** I understand that Chesterton Physical Therapy may document medical and other information related to my treatment in electronic and other forms and that such information will be in the course of my treatment, for payment purposes and to support those who are caring for me. I authorize my clinician(s) and Chesterton Physical Therapy's administrative staff to contact other health professionals that may have information related to my prior and current health conditions and treatment. I acknowledge that I have received Chesterton Physical Therapy's Notice of Privacy Practices and that it outlines how my health information will be used and disclosed and how I may gain access to and control my health information.

**6.** **HIPAA CONSENTS:** In compliance with HIPAA regulations, I consent to the following individuals receiving verbal information regarding the billing of my account:

| _____ | _____ | _____ |
|---|---|---|
| Name/Relationship | Name/Relationship | Name/Relationship |

I also authorize the release of appointment information left in a voice-mail, answering machine or text message and understand that there is some level of privacy risk associated with these forms of communication.

**7.** **EMERGENCY CONTACT:**

Name: _____ Phone Number: _____

By my signature below, I certify that I have read, and I understand and fully agree to each of the statements in this document and sign below freely and voluntarily.

Signature of Patient or Legally Responsible Person: _____ Date: _____

Printed Name of Above: _____ Date: _____

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# No-Show / Cancellation Policy

*Please Read Carefully*

**NO SHOW FEE $50.00**
(When you don't attend or call to change your scheduled appointment)

To avoid a no-show fee, you must call to reschedule your appointment before your appointment time.
*Repeated No-Shows may result in being discharged from care after 2 missed sessions.*

**SAME DAY CANCELLATION FEE: $30**
(When you call to cancel your appointment on the same day as your scheduled appointment)

*Repeated cancelled/rescheduled may result in needing to schedule with a "walk-in" or same day appointment status and discharge from care after 3 cancellations.*

**Please provide our office with 24-hour notice to change or cancel an appointment.**

*Thank you for providing our office and our patients with this courtesy.*

I acknowledge that I have reviewed the policy and understand that failure to complete any part of my treatment program will reduce my chances of success.

Signature of Patient/Guardian: _____ Date: _____

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# Medical History

Existing or Relevant Previous Conditions

| | | | | | |
|---|---|---|---|---|---|
| Allergies | ○ Yes ○ No | Dizzy Spells | ○ Yes ○ No | MRSA | ○ Yes ○ No |
| Anemia | ○ Yes ○ No | Emphysema/Bronchitis | ○ Yes ○ No | Multiple Sclerosis | ○ Yes ○ No |
| Anxiety | ○ Yes ○ No | Fibromyalgia | ○ Yes ○ No | Muscular Disease | ○ Yes ○ No |
| Arthritis | ○ Yes ○ No | Fractures | ○ Yes ○ No | Osteoporosis | ○ Yes ○ No |
| Asthma | ○ Yes ○ No | Gallbladder Problems | ○ Yes ○ No | Parkinsons | ○ Yes ○ No |
| Autoimmune Disorder | ○ Yes ○ No | Headaches | ○ Yes ○ No | Rheumatoid Arthritis | ○ Yes ○ No |
| Cancer | ○ Yes ○ No | Hearing Impairment | ○ Yes ○ No | Seizures | ○ Yes ○ No |
| Cardiac Conditions | ○ Yes ○ No | Hepatitis | ○ Yes ○ No | Smoking | ○ Yes ○ No |
| Cardiac Pacemaker | ○ Yes ○ No | High Cholesterol | ○ Yes ○ No | Speech Problems | ○ Yes ○ No |
| Chemical Dependency | ○ Yes ○ No | High/Low Blood Pressure | ○ Yes ○ No | Strokes | ○ Yes ○ No |
| Circulation Problems | ○ Yes ○ No | HIV/AIDS | ○ Yes ○ No | Thyroid Disease | ○ Yes ○ No |
| Currently Pregnant | ○ Yes ○ No | Incontinence | ○ Yes ○ No | Tuberculosis | ○ Yes ○ No |
| Depression | ○ Yes ○ No | Kidney Problems | ○ Yes ○ No | Vision Problems | ○ Yes ○ No |
| Diabetes | ○ Yes ○ No | Metal Implants | ○ Yes ○ No | | |

**Fall History**

Injury as a result of a fall in the past year? ○ Yes ○ No

Two or more falls in the last year? ○ Yes ○ No

Patient is at risk for falls? ○ Yes ○ No

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## Surgical History

| Body Regions | Surgery Type | Date |
|---|---|---|
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## Current Medications

| Drug | Dosage / Frequency | Reason |
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