Patient Registration

Patient Information:

First Name | MI | Last Name

DOB | Age | Gender | SSN

Address | City | State | Zip

Cell Phone | Other Phone (optional)

Email Address

For my convenience, I agree that my therapist may communicate and use Protected Health Information with me via the following unencrypted message types (check all that apply):

☐ Voice Mail ☐ Text Message ☐ Email

Emergency Contact:

Name | Phone | Relationship to Patient

Insurance Information:

Is the patient the primary member of the health plan? ☐ Yes ☐ No (Complete the following)

Primary Member's Full Name | Primary Member's DOB | Relationship to Patient

☐ Check this box if you have provided a photocopy of your health insurance card(s), and skip the following.

Primary Insurance Plan | Member ID | Group #

Secondary Insurance Plan (if any) | Member ID | Group #

Billing Information:

☐ Check this box if the billing name, address, and phone are the same as the patient's above, and skip this section.

Name | Phone

Address | City | State | Zip

By signing below, I confirm that the above information is true and accurate.

Patient/Guardian | Date

Medical History

Name: _____ Date: _____

You	Family	Condition
☐	☐	Heart Disease
☐	☐	High Blood Pressure (Hypertension)
☐	☐	Low Blood Pressure (Hypotension)
☐	☐	Pneumonia
☐	☐	Asthma
☐	☐	Concussion/Head Injury
☐	☐	Vertigo/Dizziness
☐	☐	Osteoarthritis
☐	☐	Rheumatoid Arthritis
☐	☐	Osteoporosis/Osteopenia
☐	☐	Gout
☐	☐	Cancer
☐	☐	Infectious Disease
☐	☐	Thyroid Disease
☐	☐	Seizures
☐	☐	Stroke/CVA/TIA
☐	☐	Blood Clots/DVT
☐	☐	Vascular Disease
☐	☐	Diabetes
☐	☐	Fibromyalgia
☐	☐	Other condition(s):_____
		_____

(Check all that apply)

Surgical History	Year Undergone
_____	_____
_____	_____
_____	_____

Cigarette Smoking: ☐ Current ☐ Used to ☐ Never

Acknowledgement Form

Consent to Undergo Physical Therapy Evaluation and Treatment

I hereby consent to evaluation and treatment of my condition by a licensed physical therapist employed by or under contract with Spirit Physical Therapy (DBA for Friedrichs Physical Therapy, LLC). I understand that the benefits of treatment may include decreased pain, increased mobility, and improved function, but that no guarantee of such results can be made. Furthermore, I understand that the risk of physical therapy treatment includes possible musculoskeletal discomfort and, although unlikely, further irritation of the condition for which I am seeking treatment, or any other condition I may have. I understand that I will have the opportunity to have all of my questions answered by my physical therapist prior to undergoing any treatment.

_____

Patient / Guardian Signature

Privacy Policy and Limited Use of Protected Health Information

I acknowledge that I may request a copy of the Spirit Physical Therapy Privacy Policy at any time. I hereby authorize Spirit Physical Therapy to disclose and/or receive my (or my dependent's) Protected Healthcare Information for the sole purposes of treatment, payment, or healthcare operations, unless otherwise instructed in writing by me.

_____

Patient / Guardian Signature

Waiver and Release

I hereby release Spirit Physical Therapy, and its employees and affiliates, from all liability, claims, demands, or causes of action related to 1) loss or damage of my personal belongings 2) my refusal to accept or allow emergency medical services, including but not limited Emergency Medical Technician care and ambulance transport.

_____

Patient / Guardian Signature

Authorization of Payment and Financial Agreement

I hereby assign all health insurance reimbursements directly to Friedrichs Physical Therapy, LLC (DBA Spirit Physical Therapy) for physical therapy services rendered to me. I agree that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. I agree that I will be responsible for non-covered charges, including those for disbursed rehabilitation equipment and a $25.00 fee for each no-show appointment. I further agree that if my account becomes delinquent, I may be assessed a late fee of 10% or $15.00, whichever is greater, and that my account may be forwarded to a collections agency and/or reported to a credit bureau.

_____

Patient / Guardian Signature

_____ _____

Printed Name Date