Pro-Active Physical Therapy of McCall, P.A.
Patient Registration

☐ I am a returning patient and my patient information and insurance information was verbally verified.

Case Name (for office use:) _____ Today's Date: _____

Last Name:	**First Name:**	**Initial:**
SSN # (optional):	**Birth Date:**	M F
Cell Phone #: I would like text message appointment reminders Y N	**Home Phone #:**	Marital Status: S M D W
Emergency Contact Name: Relationship to patient: Phone #:		
Mailing Address:	E-Mail Address: (by providing, I authorize PAPT to use for billing statements and other correspondence)	
Employer (required for workers' compensation):	Employer Phone #:	
Referring Physician:	Surgery Date (if applicable):	
Date of Injury (if applicable):	Surgeon:	
Have you had physical therapy elsewhere during the insurance plan year? ☐ Yes ☐ No		
Primary Insurance Company: Policy/Claim#:	Primary insured on this policy: ☐ Self ☐ Other If "Other", Relationship to patient: Name: DOB (mm/dd/yy):	
Secondary Insurance Company: Policy/Claim#:	Primary insured on this policy: ☐ Self ☐ Other If "Other", Relationship to patient: Name: DOB (mm/dd/yy):	

I certify that all of the above information is correct and I will inform the office of any changes.

Office Use for Insurance Benefit Look-Up:

Dates of Plan Year: _____ Co-Pay: _____

Deductible	Individual:	_____	Amount met:	_____
	Family:	_____	Amount met:	_____
Out of Pocket	Individual:	_____	Amount met:	_____
	Family:	_____	Amount met:	_____

Insurance coverage: _____

_____

Maximum visits: _____ Number of visits used: _____ Combined with OT/Speech? Y / N

Is a referral required? _____ Date of referral: _____

Is pre-authorization required? _____ Authorized visits and date range: _____

This is a benefit estimate from my insurance company and is not a guarantee of payment. By signing below, I confirm an employee of ProActive Physical Therapy has reviewed my insurance benefits with me.

_____ _____ _____

Patient Signature Date PAPT Employee

Pro-Active Physical Therapy of McCall, P.A.
Office Policies and Procedures - Please read carefully

Consent To Treat: I consent to, and authorize the physical therapists at Pro-Active Physical Therapy of McCall to furnish me/my dependents with necessary physical therapy care. The physical therapy care may include evaluation, muscle testing, range of motion measurements, hot/cold pack, electrical stimulation, ultrasound, therapeutic exercise, neuromuscular re-education, therapeutic activities for functional retraining, gait training, traction, massage, myofacial release, joint/spinal mobilization, muscle energy, and manual therapy as may be required.

Cancellation Policy: I am required to attend all scheduled appointments. If I am unable to attend a therapy session, I am required to call and cancel/reschedule the appointment **before 1 p.m. the day prior.** Failure to do so will result in a charge being added to my account balance. I may leave a message on the clinic's voice mail if cancellations are required during non-working hours. Three or more cancellations in any four-week period will result in the **suspension of formal physical therapy**. PAPT will notify worker's compensation adjusters of any non-compliance. **The cancellation/no-show fee is $25.**

Assignment of Insurance Benefits: I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf be made to Pro-Active Physical Therapy of McCall, P.A. I authorize any holder of my medical information to release to be released to the Centers for Medicare and Medicaid services and their agents or any other insurance company information required to determine benefits and process my claims.

Authorization to Use and Disclose Patient Information: I authorize the use and disclosure of my protected health information for the following purposes: to communicate with PAPT and other health professionals who participate in my care, as legal documentation describing the care I receive, to certify to a third party payer, services provided to me, to provide public health officials with information as authorized by Federal law, to assist in planning my care and treatment. I authorize my protected health information to be disclosed to my INSURANCE COMPANY, PHYSICIAN and/or ATTORNEY. I understand PAPT may use and disclose my protected health information as required by law, including but not limited to, by statute, regulation, or court orders, to the extent the use or disclosure complies with and is limited to the relevant requirements of such law. I agree this authorization will be effective from the date I sign this document until it expires as noted on this document or until I revoke this authorization in writing. I acknowledge that I access to the notice of privacy practices and am entitled to a copy of it if I desire one. **By my signature below, I agree my protected health information may be used and disclosed as described above.**

Acknowledge of Financial Responsibility: I understand that I am financially responsible for payment of medical charges incurred on my or my dependents behalf at Pro-Active Physical Therapy of McCall, P.A., regardless of third party coverage. This includes personal insurance, workman's compensation, auto insurance, and disability insurance. If I have insurance coverage, I am responsible for co-pays, co-insurance and/or deductible amounts. I understand that insurance will be billed on my behalf as a courtesy not an obligation. If anything changes with my insurance benefits, it is my responsibility to inform PAPT as soon as possible. If I do not have insurance, I understand self pay options are available and payment will be due at the time of service. I understand that I will be responsible for any balance remaining after 45 days from the date of billing. I understand that if a mutually agreed upon payment arrangement has not been made with the Practice Manager, any unpaid balance could be referred to collections.

Acknowledge of Understanding of Policies and Procedures

I have read and understand the information contained in this registration packet.

Printed Name of Patient	Signature of Patient	Date

Pro-Active Physical Therapy of McCall, P.A.
Laser Therapy Self-Pay Agreement

Laser therapy is an FDA cleared modality for the treatment of pain and inflammation and the temporary increase of microcirculation. Increased microcirculation can provide relief for many acute and chronic conditions. This form is a tool to help your clinician determine if you are a candidate for laser therapy. If you answer yes to any of these questions you will need to discuss details of your condition with your clinician.

Please check YES or NO to the questions below:

YES ☐	NO ☐	Do you have a pacemaker or any other implanted devices?
YES ☐	NO ☐	Are you pregnant?
YES ☐	NO ☐	Do you have cancer?
YES ☐	NO ☐	Are you taking medications that may increase your sensitivity to light?
YES ☐	NO ☐	Have you had a steroid injection in the last 7 days?

Laser Treatment Costs

0 - 8 minutes	$15 per treatment
8 - 23 minutes	$30 per treatment
24 - 38 minutes	$60 per treatment

Consent to Treat

I consent to, and authorize the physical therapists at Pro-Active Physical Therapy of McCall to furnish me/my dependents with necessary laser treatment for physical therapy care.

Acknowledge of Financial Responsibility

I understand that I am financially responsible for payment of medical charges incurred on my or my dependents behalf at Pro-Active Physical Therapy of McCall, P.A., regardless of third party coverage.

If I have insurance, I understand that it may not cover laser treatments. I understand that I am responsible for any balance not paid by insurance. I understand that if a mutually agreed upon payment arrangement has not been made with the Practice Manager, any unpaid balance could be referred to collections.

_____ _____

Signature of Patient Date

BASIC INFO

Name: _____ Date: _____

What brings you to physical therapy? _____

Did you have surgery? _____ If yes, when? _____ if yes, what type? _____

CHIEF COMPLAINT

What date did your symptoms start? _____

What brought on your symptoms? _____

What are your symptoms? Please check the applicable symptoms. We will go over in your evaluation.

_____ Pain	_____ Tenderness	_____ Swelling
_____ Muscle tightness	_____ Joint stiffness	_____ Restricted motion
_____ Weakness	_____ Other, _____	

PAIN SCALE

If you have pain, on a scale from 1 to 10 what is your current pain level? _____

Worst pain? _____ Least pain? _____

AGGRAVATING FACTORS

Please check the activities that cause you problems related to your current symptoms:

_____ Sleeping	_____ Looking over your shoulder	_____ Walking on flat surfaces
_____ Rolling in bed	_____ Looking up	_____ Walking on uneven surfaces
_____ Lying on back	_____ Looking down	_____ Walking up stairs
_____ Lying on stomach	_____ Reaching forward	_____ Walking down stairs
_____ Lying on side	_____ Reaching above your head	_____ Running
_____ Getting up or down from lying	_____ Reaching behind your head	_____ Jumping
_____ Sitting	_____ Reaching behind your back	_____ Working
_____ Standing up from sitting	_____ Squatting down	_____ Exercising
_____ Standing	_____ Bending forward	_____ Getting down and up from floor
_____ Balance	_____ Lifting	_____ Other activities _____
_____ Standing on one foot	_____ Carrying	_____

MEDICAL HISTORY

Do you currently have or have you had any of these health problems:

_____ Previous injuries	_____ Surgery, type _____	_____ Accidents
_____ Cancer, type _____	_____ Heart Disease	_____ Diabetes
_____ Arthritis	_____ Allergies	_____ Circulation Problems
_____ Decreased sensation	_____ Broken Bones	_____ Breathing Problems

_____ Other, _____

Please provide your: Weight: _____ lbs. Height: _____

CURRENT MEDICATIONS

Are you taking any medication now? Please list the medications(s) below or on the reverse of this page. If you have a list please give it to the front desk to copy.

PATIENT GOAL'S

What are your goals that you would like to achieve through physical therapy?