Patient Registration Form

PATIENT INFORMATION

Patient Name: | **Account Number:**

Date of Birth: | **Age:** N/A | **SS#:** | **Gender:**

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown

Home Phone: **Cell:** **Work:**

Email:

Address:

EMPLOYER INFORMATION:

Employer:

Employment Status: ☐ Active Military ☐ Full-Time ☐ None ☐ Part-Time ☐ Retired ☐ Self Employed

Address:

Phone: **Occupation:**

INSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance:**
Policy #:	**Policy #:**
Group #:	**Group #:**
Subscriber's Name:	**Subscriber's Name:**
Subscribers DOB:	**Subscribers DOB:**
Relation to Patient:	**Relation to Patient:**

INJURY INFORMATION

My Injury is Related To: ___ Work ___ Auto ___ Sports ___ None **DOI:**

Injury Area: **Referring Doctor:**

WHY DID YOU CHOOSE CACC (Choose one)

☐ Accommodating Hours	☐ Attorney	☐ Billboard	☐ Convenient Location
☐ Email	☐ Employer	☐ Family	☐ Former Patient
☐ Friend	☐ Insurance Carrier	☐ Internet Search	☐ Medical Office Staff
☐ Medical Provider	☐ Online Reviews/Ratings	☐ Other	☐ CACC Website
☐ Print Ad	☐ Self Referral/Direct Access	☐ Sign	☐ Social Media
☐ Specialty Program	☐ Therapist's Certification	☐ WC Panel of Providers	

RESPONSIBLE PARTY (Guarantor)

Name: | **Date of Birth:**

Phone: | **Relation:**

EMERGENCY CONTACT

Emergency Contact Name:

Emergency Contact Relation: **Emergency Contact Phone:**

Patient, Please sign here if the above information is complete and correct **Date**

Injury and Past Medical History Questionnaire

Patient Name: _____ DOB: _____ Date: _____

When did the condition for which you are seeking treatment begin? _____

Please describe the history and onset of the present condition: _____

_____

_____

Date of Surgery (if applicable): _____ Type of Surgery: _____

What are your chief complaints due to your condition? Please check all that apply.

- ☐ `Awakened by pain
- ☐ Burning
- ☐ Difficulty falling asleep
- ☐ Difficulty finding a comfortable sleeping position
- ☐ Difficulty walking
- ☐ Diminished motion
- ☐ Dizziness
- ☐ Fatigue
- ☐ `Headaches
- ☐ Irritability
- ☐ Loss of function
- ☐ Loss of motion - stiffness
- ☐ Nausea
- ☐ Numbness
- ☐ Pain
- ☐ Constant Pain
- ☐ `Pain worse in the AM
- ☐ Pain worse in the PM
- ☐ Pain worse with activity
- ☐ Spasm
- ☐ Swelling
- ☐ Tingling
- ☐ Weakness
- ☐ Other _____

If you have pain, please rate your pain today on a scale of 0 to 10? (0 is no pain, and 10 is worst possible pain or symptoms): /10

Where is your pain located and how would you describe it? _____

_____

Rate your symptom intensity in the past 5 days:

Symptoms at their worst: /10

Symptoms at their best: /10

Please list any contraindications to treatment or precautions that we should know: _____

_____

Occupation: _____

Work Status:

☐ Employed Full Time ☐ Employed Part Time ☐ Not employed
☐ Full time student ☐ Part time student ☐ Permanently Disabled
☐ Retired

Current Ability to work:

☐ Full Duty ☐ No formal restrictions ☐ Off work
☐ Restricted duties/schedule

Please outline restrictions: _____

_____

Normal work duties:

- ☐ Sitting for extended periods
- ☐ Standing for extended periods
- ☐ Typing/computer operation
- ☐ Repetitive Bending
- ☐ Repetitive Lifting
- ☐ Lifting moderate weights
- ☐ Lifting Heavy Weights
- ☐ Walking
- ☐ Operating Heavy Equipment
- ☐ Driving

Which of these duties are you not currently able to perform and why? _____

_____

Patient Name: _____ DOB: _____ Date: _____

Please list any surgeries and procedures		
Type of Surgery	When	Results/Details

Please list any diagnostic tests and results related to your current condition		
Test	When	Results/Details

Please list other specialists seen for your current condition other than prescribing physician			
Name	Specialty	Reason	Date of Last Visit

Please enter your current height: _____ Please enter your current weight: _____

Please mark beside all conditions that you have a history of:

- ☐ Allergies
- ☐ Anxiety
- ☐ Asthma
- ☐ Bowel Dysfunction
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Headaches
- ☐ Heart Condition
- ☐ History of Smoking
- ☐ High Blood Pressure
- ☐ Joint Replacement
- ☐ Malaise/Fatigue
- ☐ Mental/Cognitive Disorder
- ☐ Metal Implants
- ☐ Nausea/Vomiting
- ☐ Neurological Disorder
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pregnancy (current)
- ☐ Rheumatoid Arthritis
- ☐ Shortness of Breath
- ☐ Stroke/CVA
- ☐ Syncope/Fainting
- ☐ Recent Weight Change
- ☐ Other _____

Please list all medications and supplements that you are presently taking			
Name of Medication/Supplement	Route of Administration (Oral, topical, etc)	Dosage	Frequency of Use

Have you fallen in the past 12 months? ☐ Yes ☐ No If so, how many times? _____

If you have fallen, did any fall result in an injury? ☐ Yes ☐ No ☐ N/A

Have you recently been hospitalized? ☐ Yes ☐ No If so, when were you discharged? _____

Have you received therapy in the past 12 months? ☐ Yes ☐ No If yes, how many visits? _____

In what type of home do you live? ☐ Single Level Home ☐ 2 Level Home ☐ Ground Floor Apartment ☐ Upper Level Apartment ☐ Other: _____

With whom do you live? ☐ Spouse ☐ Parent(s) ☐ Children ☐ Alone ☐ Other: _____

Are there stairs at home? ☐ Yes ☐ No If so, how many? _____

Is there a handrail? ☐ Yes ☐ No If yes, ☐ Right Side only ☐ Left Side only ☐ Both Sides

Where is the bathroom located? ☐ Lower Level ☐ Upper Level

Where is the bedroom located? ☐ Lower Level ☐ Upper Level

Do you currently smoke? ☐ Yes ☐ No If so, how many packs per day?

Did you smoke in the past? ☐ Yes ☐ No If so, how many packs _____ years _____

Do you use any other form of tobacco? ☐ Yes ☐ No

What are your goals and what do you expect to achieve with treatment? _____

CONSENT FOR TREATMENT AND FINANCIAL POLICY

Patient Name: DOB:

We would like to THANK YOU for choosing Colorado Athletic Conditioning Clinic (CACC). CACC accepts third party payments and will submit your bills for treatment to the address provided as a courtesy to you. In order for us to bill your insurance company on a regular basis, we request that you sign this release of information and assignment of benefits (if applicable). Typically, insurance companies pay a predetermined amount of our treatment charges; however, it is your responsibility to call your insurance company to check on the coverage provided by your individual policy. As a courtesy to you, we will perform an insurance verification with your insurance company; however, we do not take responsibility for any misinformation that we are given during this process. It is within your best interest to verify your outpatient benefits with your individual insurance plan and to confirm with our office prior to initiating treatment.

CONSENT FOR CARE AND TREATMENT

I hereby consent to the provision of treatment by CACC. I authorize CACC to furnish treatment which is considered necessary and proper in diagnosing or treating my physical condition. It is possible that my participation in the visit could result in injury to me. I also acknowledge and fully understand that I am engaging in activities that may involve the risk of economic and other damages which might result from my own actions or omissions, from the actions or omissions of other parties, or from any of the activities I am asked to complete during this visit. I further agree that there may be other risks not known to me or not reasonably foreseeable at this time. Nonetheless, it is my desire to participate in this visit. Accordingly, I release, waive, discharge and covenant not to sue CACC, any of its employees, representatives, officers, directors, shareholders, affiliates, administrators, agents, owners, or lessors of all equipment, all of whom are hereafter referred to as "Releasees", from demands, losses or damages on account of injuries, including death or damage to property, caused or alleged to be caused in whole or in part by the negligence of the Releasees or otherwise.

I hereby authorize and designate the following individual to act in all matters in connection with my treatment by CACC, including, without limitation, discuss my therapy plan of care, and schedule and cancel my appointments

First and Last Name Phone Number Relationship to Patient

FINANCIAL RESPONSIBILITY

I understand that in some instances my health insurance may not cover all treatment charges incurred. I agree to be financially responsible to CACC for any medically necessary therapeutic services that are not covered by my health insurance carrier. In addition, I authorize CACC to release (a) any medical or other information about CACC services, or services provided by third parties, if required to obtain payment from my insurer or other payer and their agents to process payments; (b) any medical or other information required by my insurer, other payers and their agents; and (c) medical or other information required by my insurer, other payers and their agents, government agencies or their designees for review of the care provided to me.

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to CACC any benefits payable to me and/or my qualified dependents under the insurance coverage or Major Medical provisions of insurance coverage identified on bills submitted by CACC for treatment. By way of my signature below, I provide CACC with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment, and health care operations as described in the Notice of Privacy Practices.

CO-PAYMENTS, COINSURANCE AND DEDUCTIBLES

I understand that if my insurance plan requires a co-payment, coinsurance, and/or deductible for treatment, payment will be collected at the time of my visit, according to my insurance benefits and the following CACC policy to reduce the balance billed to me at the end of care: Copays are collected in full at the time of service. Balances towards deductible and coinsurance will be collected as insurance(s) processes claims throughout the course of treatment. Any outstanding balances due at the end of each month will be billed to the patient.

CONSENT FOR TREATMENT AND FINANCIAL POLICY

Patient Name: _____ DOB: _____

LITIGATION ACCOUNTS

With respect to litigation against another party, I understand that CACC will directly bill my appropriate insurance; however, I am responsible for the payment of my treatment, not the entity being sued. Liability action against another party will not enable me to refuse payment to CACC. I fully understand that I am directly and fully responsible to CACC for all medical bills submitted by CACC for services rendered to me regardless of whether my claims are settled or result from a court judgement.

PATIENT VALUABLES

I relieve CACC of any responsibility for loss of clothing, money, valuables, or other items that I decide to keep with me while I am a patient. I also understand that CACC will not be responsible and will not replace any property lost, broken, or stolen, which I decide to keep with me, or any property brought to me while I am a patient.

CONSENT TO RECEIVE EMAIL, TEXT MESSAGES, AND CALLS FOR APPOINTMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS

I consent to receive email, text messages, and calls from CACC for my protected health care and other services at the email address and phone number(s), including my wireless number, that have been provided during the intake process. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system. I understand that providing an email address and/or phone number is not a condition of receiving treatment. I am aware that e-mail communication can be intercepted in transmission or misdirected. I also understand that I may revoke my consent for contact at any time by directly contacting CACC or utilizing the opt-out method that will be identified in the applicable communication.

MINOR ABLE TO CONSENT FOR CARE (IF APPLICABLE)

I am under 18 years of age and for the following reason(s)_____
I am entitled under State Law to consent to medical or other health services for myself, and if applicable, for my minor children without the consent of any other person: _____ Patient Initials (required if completing this section)

CERTIFICATION OF IDENTITY

I certify that I am in fact the individual I claim to be. I understand that the knowing and willful use of another individual's personal identifying information under false pretenses is a criminal offense.

FOR OFFICE USE ONLY

Verification of the identity of the above-named party was made by:

☐ Current Driver's License or other Photo ID

☐ Current Health Insurance Card

☐ Other:

I have read this Consent for Treatment and Financial policy form or have had it read to me, and it has been explained to my satisfaction. I understand that this consent for Treatment, Payment and Health Care Operations form may be valid for up to one (1) year from the date that I sign it and applies to all CACC facilities.

_____ _____

Signature of Patient or Guardian (if patient is a minor) **Date**

_____ _____

Signature of CACC Representative **Date**

CACC PHYSICAL THERAPY

Patient Name _____ **Medicare ID#** _____

MEDICARE SECONDARY PAYOR FORM		
YES	**NO**	**QUESTIONS**
		1. Are you receiving Black Lung Benefits? If NO, proceed to Question #2. If YES, BL is primary only for claims related to BL.
		2. Are the services to be paid by a government program such as research grant? If NO, proceed to Question #3. If YES, Government program will pay primary benefits for these services.
		3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility? If NO, proceed to Question #4. If YES, DVA is primary for these services.
		4. Was the illness /injury due to a work related accident/condition? If NO, proceed to Question #5. If YES, complete blanks below: Date of injury/accident_____/_____/_____ Name/Address of WC plan_____ Policy Number _____ Name/Address of Employer _____ _____ (WC is primary for claims related to work related injuries or illness)
		5. Was the illness/injury due to a non-work related accident? If NO, proceed to Question #6. If YES, complete blanks below: Date of accident_____/_____/_____ Cause: Auto_____ Non-auto_____Other Party Responsible_____ Name/Address of Auto or Liability Insurer _____ _____ Insurance claim # _____ (Auto/Liability Insurer is primary payer for claims related to the accident)
		6. Are you entitled to Medicare based on Age? (Age 65 or over) If NO, proceed to Question #7. If YES, go to AGE QUESTIONS (On Page 2).
		7. Are you entitled to Medicare based on Disability? If NO, proceed to Question #8. If YES, go to DISABILITY QUESTIONS (On Page 2).
		8. Are you entitled to Medicare based on ESRD (End Stage Renal Disease)? If YES, go to ESRD QUESTION #3 (On Page 2).

Patient Name _____ **Medicare ID#** _____

MEDICARE SECONDARY PAYOR FORM		
YES	**NO**	**Age, Disability, & ESRD Questions**
		1. Are you currently employed? If NO, Retirement Date_____/_____/_____ If YES, Name/Address of Employer
		2. Is your spouse or family member currently employed? If NO, Retirement Date_____/_____/_____ If YES, Name/Address of Employer
		3. Do you have Group Health Plan (GHP) coverage based on your own or your family member's current employment? If NO, Medicare is primary. (STOP QUESTIONNAIRE HERE!) If YES, For AGE …GO TO 4a. For DISABILITY…GO TO 4b. For ESRD…GO TO 4c.
		4a. AGE: Does the employer that sponsors your GHP employ 20 or more employees? **4b. DISABILITY: Does the employer that sponsors your GHP employ 100 or more employees?** **4c. ESRD: Date of kidney transplant?_____/____/____ Date dialysis began?_____/____/____** **(GHP is primary for 30 month coordination period…complete info below)** If NO, Medicare is primary. If YES, GHP is primary. Complete the information below: Name/Address of GHP _____ _____ ID #_____Group # _____ Policy Holder_____Relation to patient _____

HOME HEALTH PROSPECTIVE PAYMENT SYSTEME (Yes or No)

Have you received any medical care (ex. PT, OT, ST, Nursing, Aide, etc.) from a Home Health Agency in the past 60 days? YES_____ NO_____

MEDICARE PAYMENT AUTHORIZATION

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other informationabout me to release to the Social Security Administration and Centers for Medicare Services or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request that payment of authorized benefits be made on my behalf to CACC. This authorization is valid for a period of 2 years from the date which I have signed.

Patient or Authorized Signature _____ **Date** _____

Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or health care operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by CACC (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any health care operations that are permitted in the Privacy Regulations.

2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.

3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: 2000 Westinghouse Drive, Suite 200, Cranberry Township, PA 16066, Attention: Compliance Officer.

4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or health care operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me except in very limited circumstances as described in the Privacy Notice, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions):

_____

_____

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and health care operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

_____ _____

Signature of Patient or Representative **Date**

_____

Patient's Name

_____

DOB

_____ _____

Name of Personal Representative (if applicable) **Relationship to Patient**

To Be Completed by the Practice

The requested restrictions on the use and/or disclosure of the patients health information set forth above are:

Accepted _____ Denied _____ Not Applicable _____

Other (explain) _____

Signature of Authorized Practice Representative: _____ **Da**te: _____