ALLIED | PHYSICAL THERAPY PLLC

Patient Registration

Commercial and Medicare patient intake

Please complete all applicable information so we can process your insurance claim.

TODAY'S DATE

LAST NAME

FIRST NAME / MI

DATE OF BIRTH

PHONE

MOBILE PHONE

EMAIL ADDRESS

REFERRAL SOURCE

STREET ADDRESS

CITY

STATE

ZIP CODE

PRIMARY CARE PHYSICIAN

PRIMARY INSURANCE

INSURANCE CARRIER

INSURED NAME

POLICY / MEMBER ID

GROUP NUMBER

RELATIONSHIP TO PATIENT

INSURANCE PHONE

SECONDARY INSURANCE (IF APPLICABLE)

INSURANCE CARRIER / INSURED NAME

POLICY / MEMBER ID

GROUP NUMBER

RELATIONSHIP TO PATIENT

Patient Health Questionnaire

Symptoms, function and treatment goals

PATIENT NAME

DATE

1. MAIN COMPLAINT AND WHEN SYMPTOMS BEGAN

SYMPTOM DETAILS

2. FREQUENCY

- [ ] Constant
- [ ] Frequent
- [ ] Occasional
- [ ] Intermittent

3. TYPE

- [ ] Sharp
- [ ] Shooting
- [ ] Dull ache
- [ ] Burning
- [ ] Numb
- [ ] Tingling

OTHER

4. SYMPTOMS ARE

- [ ] Getting better
- [ ] Not changing
- [ ] Getting worse

5. PAIN RATING

Worst (0-10)

Best (0-10)

Current (0-10)

6. INTERFERENCE WITH DAILY ACTIVITIES

- [ ] None
- [ ] Mild
- [ ] Moderate
- [ ] Severe

7. ACTIVITIES THAT MAKE SYMPTOMS WORSE

8. ACTIVITIES THAT MAKE SYMPTOMS BETTER

9. PREVIOUS PROVIDERS, TREATMENTS OR DIAGNOSTIC TESTS (INCLUDE DATES)

10. SIMILAR SYMPTOMS BEFORE?

- [ ] Yes
- [ ] No

11. TREATMENT GOALS

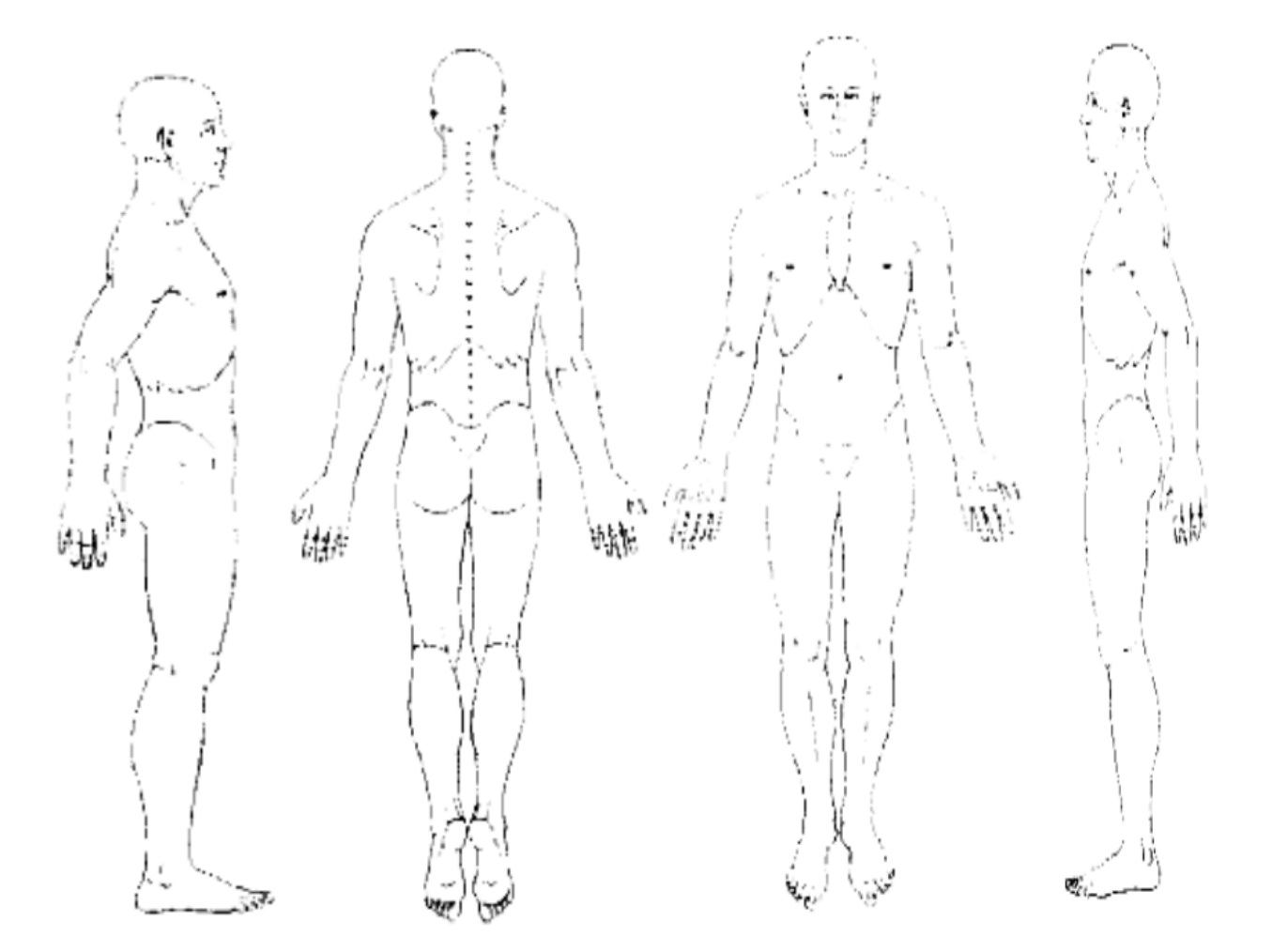
- [ ] Reduce symptoms
- [ ] Resume activities
- [ ] Understand condition
- [ ] Self-management
- [ ] Prevent recurrence

Body Pain Diagram

Mark X for pain, N for numbness, and T for tingling

PATIENT NAME

DATE



ADDITIONAL NOTES / SYMPTOM LOCATION

Patient Medical History

Mark Past and/or Current for each condition

PATIENT NAME

DATE

EXERCISE ☐ None ☐ Light ☐ Moderate ☐ Strenuous

HEIGHT

WEIGHT

MEDICAL CONDITIONS | P = PAST / C = CURRENT

☐ P	☐ C	Headaches	☐ P	☐ C	General fatigue	☐ P	☐ C	Loss of appetite
☐ P	☐ C	Neck pain	☐ P	☐ C	Muscular incoordination	☐ P	☐ C	Abdominal pain
☐ P	☐ C	Upper back pain	☐ P	☐ C	Visual disturbances	☐ P	☐ C	Ulcer
☐ P	☐ C	Mid back pain	☐ P	☐ C	Dizziness	☐ P	☐ C	Hepatitis
☐ P	☐ C	Low back pain	☐ P	☐ C	High blood pressure	☐ P	☐ C	Liver / gallbladder disorder
☐ P	☐ C	Shoulder pain	☐ P	☐ C	Heart attack	☐ P	☐ C	Cancer
☐ P	☐ C	Elbow / upper arm pain	☐ P	☐ C	Chest pain	☐ P	☐ C	Tumor
☐ P	☐ C	Wrist pain	☐ P	☐ C	Stroke	☐ P	☐ C	Asthma
☐ P	☐ C	Hand pain	☐ P	☐ C	Angina	☐ P	☐ C	Chronic sinusitis
☐ P	☐ C	Hip / upper leg pain	☐ P	☐ C	Kidney stones	☐ P	☐ C	Diabetes
☐ P	☐ C	Knee / lower leg pain	☐ P	☐ C	Kidney disorders	☐ P	☐ C	Excessive thirst
☐ P	☐ C	Ankle / foot pain	☐ P	☐ C	Bladder infection	☐ P	☐ C	Frequent urination
☐ P	☐ C	Jaw pain	☐ P	☐ C	Painful urination	☐ P	☐ C	Tobacco use
☐ P	☐ C	Joint swelling / stiffness	☐ P	☐ C	Loss of bladder control	☐ P	☐ C	Drug / alcohol dependence
☐ P	☐ C	Arthritis	☐ P	☐ C	Prostate problems	☐ P	☐ C	Allergies
☐ P	☐ C	Rheumatoid arthritis	☐ P	☐ C	Weight changes	☐ P	☐ C	Depression

ADDITIONAL HEALTH INFORMATION

OTHER CONDITIONS, PREGNANCY, HORMONAL THERAPY, MEDICATIONS OR ALLERGIES

FAMILY HISTORY (HEART DISEASE, DIABETES, CANCER, LUPUS, RHEUMATOID ARTHRITIS, OTHER)

Medical History & Daily Activities

Additional history and functional limitations

PATIENT NAME

DATE

MEDICATIONS (PRESCRIPTION, OVER-THE-COUNTER AND SUPPLEMENTS)

SURGERIES / HOSPITALIZATIONS (INCLUDE DATES)

DAILY ACTIVITIES - CHECK ANY THAT ARE DIFFICULT

- ☐ Getting in/out of chair
- ☐ Getting in/out of car
- ☐ Getting in/out of bed
- ☐ Bathing / showering
- ☐ Toileting
- ☐ Walking distances
- ☐ Housecleaning
- ☐ Preparing meals
- ☐ Laundry / household chores
- ☐ Driving
- ☐ Carrying packages
- ☐ Ascending stairs
- ☐ Descending stairs
- ☐ Gardening
- ☐ Reaching overhead
- ☐ Putting on shoes / socks
- ☐ Sports / recreation
- ☐ Foot care
- ☐ Gripping with hands
- ☐ Carrying / lifting objects
- ☐ Pushing / pulling objects
- ☐ Personal relationships
- ☐ Balance while walking
- ☐ Typing / computer / writing
- ☐ Hair care / grooming
- ☐ Prolonged sitting

OTHER DIFFICULTIES / COMMENTS

- ☐ I live alone
- ☐ I am a caregiver
- ☐ Additional details attached

PATIENT / LEGAL GUARDIAN SIGNATURE

DATE

ALLIED | PHYSICAL THERAPY PLLC

Assignment of Benefits

Insurance payment and release authorization

COMMERCIAL INSURANCE

I, the undersigned, have insurance coverage with the company identified below and assign directly to Allied Physical Therapy PLLC all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether payable or not paid by the insurance carrier. I authorize Allied Physical Therapy PLLC to release information necessary to secure payment of benefits and authorize the use of this signature on insurance claim submissions, whether manual or electronic.

INSURANCE COMPANY

PATIENT / LEGAL GUARDIAN SIGNATURE

DATE

MEDICARE INSURANCE

I request that payment of authorized Medicare benefits be made to Allied Physical Therapy PLLC for medical services rendered to me. I authorize any holder of my medical information to release information required to determine benefits or benefits payable for related services to Medicare and its agents. My signature requests payment and authorizes release of medical information necessary to pay my claims. If other health insurance is indicated on a claim form, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider accepts the Medicare-approved amount as payment in full for covered services, and I am responsible for applicable deductibles, coinsurance and non-covered services.

PATIENT / LEGAL GUARDIAN SIGNATURE

DATE

Important: Patient responsibility is subject to applicable insurance contracts and law.

Please ask our staff if you have questions before signing.

Patient Privacy Acknowledgment

Notice of Privacy Practices and communication preferences

Allied Physical Therapy PLLC uses and discloses protected health information (PHI) for treatment, payment and health care operations as described in its Notice of Privacy Practices. I acknowledge that I have been offered the opportunity to review the Notice of Privacy Practices before signing. I may request a copy of the current notice and may request restrictions on certain uses or disclosures of my information. The practice will respond to such requests in accordance with applicable law.

COMMUNICATION PREFERENCES

Please indicate how we may contact you about appointments, billing and care:

☐ Phone call ☐ Voicemail ☐ Mail ☐ Email ☐ Text message

PREFERRED PHONE / EMAIL / MAILING ADDRESS

ADDITIONAL CONTACT OR PRIVACY INSTRUCTIONS

I understand that I may ask questions about the Notice of Privacy Practices and request changes to my communication preferences. Any authorization beyond those permitted by law for treatment, payment or health care operations will be obtained separately when required.

ACKNOWLEDGMENT

☐ I acknowledge receipt of, or the opportunity to receive, the Notice of Privacy Practices.

PATIENT / LEGAL GUARDIAN SIGNATURE

DATE

PRINTED NAME / RELATIONSHIP

Informed Consent for Physical Therapy

Please read before signing

This form should be signed by the adult patient, a parent or legal guardian for a minor, or an authorized legal representative when applicable.

CONSENT TO TREATMENT

I authorize licensed physical therapists and physical therapist assistants employed by Allied Physical Therapy PLLC to provide physical therapy treatment to me or to the patient named below. I understand that treatment is recommended based on clinical evaluation and findings. A member of the physical therapy team has explained, or will explain before treatment, the nature and purpose of the proposed treatment, its potential risks and complications, and reasonable alternatives, when applicable. I have had the opportunity to ask questions, and I voluntarily consent to treatment. I understand that no particular outcome or benefit can be guaranteed. I may ask questions or withdraw consent for future treatment at any time.

PATIENT / REPRESENTATIVE

PRINTED PATIENT NAME

PATIENT / LEGAL GUARDIAN SIGNATURE

DATE

IF GUARDIAN, PRINT NAME / RELATIONSHIP

CLINICIAN ATTESTATION

I have explained the relevant treatment information and addressed the patient's or representative's questions.

CLINICIAN SIGNATURE

DATE

By signing, I confirm that I have read this form, understand it, and had an opportunity to ask questions.