It is our policy that if a patient is experiencing **ANY** Covid-19 symptoms or Flu-like symptoms, they notify us **BEFORE OR UPON ARRIVAL**. We can reschedule your appointment based upon your symptoms.

Thank you in advance for your cooperation. Please let us know if you have any questions.

Signature: ____ Date:____________

Patient Registration

Date:______________

Last Name:	First Name: Initial:
Date of Birth:	Social Security #:
Address:	City:
State: Zip Code:	
Cell Number: ( )	Work Number: ( )
Email:	How did you hear about us?

Emergency Contact:

Last Name:	First Name:
Phone: ( )	Relationship:

Employer Information:

Employer:	Phone: ( )
Address:	City/State/Zip:

Primary Insurance:

Insurance:	Member ID:
Group Number:	Claim # (if applicable):
Subscriber's Name:	Subscriber's Date of Birth:
Subscriber's Relationship to Patient:	☐ Self ☐ Spouse ☐ Parent ☐ Other:

Secondary Insurance:

Insurance:	Member ID:
Group Number:	Claim # (if applicable):
Subscriber's Name:	Subscriber's Date of Birth:
Subscriber's Relationship to Patient:	☐ Self ☐ Spouse ☐ Parent ☐ Other:

For Motor Vehicle Accident (MVA) Only:

If you are receiving care for injuries from a MVA, in what state did the accident occur?

For Workers Compensation Cases Only:

Name of Adjuster:	Phone: ( )

Financial Agreement:

Person Responsible for bill:	Birth Date:	Address (if different):	Contact Number:
Name of Employer:	Occupation:	Work Email Address:	Employer Phone Number:

The above information is current, accurate and true to the best of my knowledge. I authorize my insurance benefits to be paid directly to River Region Physical Therapy, LLC. It is *my responsibility* to keep my insurance active and accurate throughout my plan of care. I understand that I am financially responsible for any balance. I also authorize River Region Physical Therapy, LLC or insurance company to release any information required to process my claims.

Patient/Guardian Signature:	**Date:**

Medical History Questionnaire

Patient Name:

Problem/Condition:

Description of Problem:	
Referred by:	Onset Date:
Pain Rating: ☐ None ☐ Mild ☐ Severe	______ / 10
What activities aggravate your symptoms?	
What things relieve your symptoms? (medications; changing positions, etc)?	
What activities are you currently limited with that you would like to return to after completing physical therapy?	

Are you **currently** receiving any other care for the condition mentioned above? ☐ No ☐ Yes – If yes, please explain:	
Have you ever received therapy in the past for the condition mentioned above? ☐ No ☐ Yes – If yes, when?	
Have you received therapy services for other problems/conditions during the current year? ☐ No ☐ Yes – If yes, please explain:	
Do you have a pacemaker? ☐ No ☐ Yes	Could you be or are you pregnant? ☐ No ☐ Yes

Do you currently have, or have you ever had any of the following conditions?

Condition			Condition		
Osteoporosis	☐ Yes	☐ No	Fibromyalgia	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Osteo or Rheumatoid Arthritis	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Cancer / Tumor	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No	Hernia	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Parkinson's Disease	☐ Yes	☐ No	Metal in Body or		
Stroke	☐ Yes	☐ No	Surgical Implants	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	HIV / Aids	☐ Yes	☐ No
Previous Surgeries	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No

If previous surgeries, please list:______________________ Other:____

____ ____

Do you have any allergies? ☐ No ☐ Yes – If yes, please list:
Are you presently taking any medications? ☐ No ☐ Yes – If yes, please list or provide a separate list:

For Medicare Patients Only:

Are you currently receiving home care services? ☐ No ☐ Yes – If yes, expected date of completion: Do you have a home health discharge letter? ☐ No ☐ Yes

Patient/Guardian Signature:	**Date:**

RELEASE OF INFORMATION AND CONSENT FOR TREATMENT

I am aware of my diagnosis and wish to receive treatment at River Region Physical Therapy, LLC. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to River Region Physical Therapy, LLC and its subsidiaries and affiliates to release information, verbal and written, contained in my medical records, and other related information to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment and/or payment for services provided.

I authorize River Region Physical Therapy, LLC and/or its subsidiaries and affiliates to obtain medical records and/or professional information form my physician or other medical professional as it relates to my treatment.

ASSIGNMENT OF BENEFITS

I authorize payment directly to River Region Physical Therapy, LLC, its subsidiaries and/or affiliates fore services and to bill and release payment directly to River Region Physical Therapy, LLC, its subsidiaries and/or affiliates for any physical therapy, occupational therapy, speech-language pathology, rehabilitation, orthotic or prosthetic services provided.

This is a direct assignment of my rights assistive device benefits under this p9olicy. A photocopy of this assignment shall be considered as effective and valid as the original.

NOTICE OF PRIVACY PRACTICES (HIPPA ACKNOWLEDGEMENT/CONSENT)

I hereby acknowledge that I have received a copy of The Notice of Privacy Practices for River Region Physical Therapy, LLC, its subsidiaries and/or affiliates.

In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operation.

FINANCIAL RESPONSIBILITY

I understand that payment is due at the time of service. WE WILL EXHAUST ALL EFFORTS TO CONTACT YOUR INSURANCE PROVIDER AND VERIFY YOUR COPAY AND DEDUCTIBLE RESPONSIBILITY. THIS IS NO WAY IS A GUARANTEE OF BENEFITS OR GUARANTEE OF PAYMENT THAT WILL BE MADE BY YOUR INSURANCE COMPANY. THIS IS ONLY AN ESTIMATE OF THE AMOUNT WE WILL COLLECT AT THE TIME OF SERVICE. IF THERE IS ANY DIFFERENCE IN PAYMENT FROM YOUR INSURANCE COMPANY, YOU WILL BE BILLED FOR ANY BALANCE DUE ONCE YOUR CLAIM HAS BEEN PROCESSED BY YOUR INSURANCE COMPANY.

AT THIS TIME WE HAVE BEEN ADVISED THAT YOUR DEDUCTIBLE IS $___________ AND YOUR COPAY IS $_____________ OR COINSURANCE IS _________%. **INITIAL HERE___________**

“I agree to pay collection fees of 33 1/3% of the unpaid balance at such time that my account is placed with a collection agency. I further agree that I am responsible for all costs associated with the collection of my account, including but not limited to postage costs, and all credit card processing costs. In the event my account is referred to an attorney for collection, I agree to be liable for attorney’s fees of 33 1/3% of the unpaid balance, and all costs of court. I also authorize my employment location and status to be verified for the purpose of processing my bill for payment.

I authorize the use of the phone numbers and other contact information I provide, including my cellular number and any future number assigned to me, for calls, texts, emails, to include automated dialers, to contact me regarding my care and my account by this medical provider and this medical provider's business associates.

Patient/Guardian Signature:	**Date:**