Patient Registration Form

Personal Information

Name:		Name you prefer:
Home Address:		Apt #
City:	State:	Zip Code:
Mailing Address:		
City:	State:	Zip Code:
Injury/ Diagnosis:		Home Phone:
Date of Inury/Onset of symptoms:		Work Phone:
Date of Birth:	Age:	Cell Phone:
Email Address:		
Emergency Contact:	Emergency Contact Phone #:	
How did you hear about us?:		

Referring Physician Name:	Phone #:
City, State:	
Primary Care Physician Name:	Phone #:
City, State:	
Employer Name:	Occupation:
Address:	City, State:
Social Security Number (For Insurance Benefit Verification):	

Primary Insurance Information

Is this an auto accident?: Yes No If "Yes", list claim # and adjuster contact information:	Is this a worker's comp case?: Yes No	
Health Insurance Company Name:		
Subscriber's Name:	Subscriber's Date of Birth:	
Relationship to the Subscriber:		
Subcriber's Address and Phone # if different from patient:		
Address:		
City, State	Zip	Phone#

Secondary Health Insurance Information

Health Insurance Company Name:		
Subscriber's Name:	Subscriber's Date of Birth:	
Relationship to the Subscriber:		
Subcriber's Address and Phone # if different from patient:		
Address:		
City, State	Zip	Phone#

CYPRESS
PHYSICAL THERAPY

Medical History Information Sheet

1. What would you say is the pain rating for your current condition using a scale of 0 – 10? (0=no pain, 10=worst pain imaginable) ________________

2. Have you ever had any of the following conditions?

			Explain
Stroke	*yes*	*no*	________
Heart Disease or Heart Murmur	*yes*	*no*	________
High Blood Pressure	*yes*	*no*	________
Asthma	*yes*	*no*	________
Diabetes	*yes*	*no*	________
Epilepsy/Fainting	*yes*	*no*	________
Impairment of Vision or Hearing	*yes*	*no*	________
Cancer	*yes*	*no*	________
Drug Allergies	*yes*	*no*	________
Osteoporosis	*yes*	*no*	________

Orthopedic History – Please give dates & treatments received:

3. Have you ever sprained, strained, dislocated or fractured the following:

   Neck/Head (including concussion) ________________________________

   Trunk (ribs, vertebrae, sternum) ________________________________

   Low Back (vertebrae, discs, nerves) ________________________________

   Upper Extremity (shoulder, elbow, wrist, arm) ________________________

   Lower Extremity (hip, leg, knee, ankle, foot) ________________________

4. Please list any surgeries that you have had and their dates:
   ____

5. Please list medication(s) presently taking: ____________________________

6. Women: Are you pregnant? yes ________ no ________

7. Have you ever had PT in the past?________________________________
   If so, when? ____

8. **IF YOU HAVE MEDICARE, HAVE YOU EVER HAD HOME HEALTH CARE?**____________

9. If so, what is the **name and phone number** to the agency? ____________________

I agree that the above information accurately describes my medical history and that should any changes in my medical history occur, I will notify my PT immediately

Signature________________________________Date:____________________

Consent of Care and Treatment

For and in consideration of the medical treatment, which I will receive while a patient at Cypress Physical Therapy, LLC, I either severally or collectively consent to treatment, voluntarily and knowingly, by me, if of age and competent, and by a parent or legal guardian if a minor or incompetent. I authorize the said members of Cypress Physical Therapy, LLC severally or collectively, to carry out, or cause to be carried out such medical treatment as prescribed or ordered by my physician.

Authorization to Release Information and Assignment of Benefits

I hereby authorize Cypress Physical Therapy, LLC, or any holder of medical information about me, to release to the Healthcare Admisstration and it agents (Medicare, Insurance Companies, or Third Party Paryers) any information to determine those benefits or benefits payable for related services. I request that all authorized Medicare or Insurance payments of medical benefits be made to Cypress Physical Therapy, LLC, or to any consulting physician or entity used in connection with this service (to be used only if necessary to file claims).

Authorization to Release or Obtain Medical Information

I hereby authorize Cypress Physical Therapy LLC, to obtain or release copies of my medical records, relative to the diagnosis, treatment, and prognosis of my illness, injury, or condition. If there is anyone you would like to authorize the disclosure of your Personal Health Information, or PHI, you may specifically name the party below and indicate what your relationship to that party. If you are a student athlete, we MUST have all coaches, trainers, or administrative personnel that you would want to have access to the status of treatment.

1. Name:______________________________Relationship:________________________
2. Name:______________________________Relationship:________________________
3. Name:______________________________Relationship:________________________
4. Name:______________________________Relationship:________________________
5. Name:______________________________Relationship:________________________

____ ________________________

Signature of Patient/ Parent/ Legal Guardian Date

Privacy Notice

By my signature below, I acknowledge that I have received a copy of the "Notice of privacy Practices," and understand my rights as a patient regarding my personal health information.

Guarantor Responsibility

In consideration of the services, I agree that I am solitarily liable to Cypress Physical Therapy LLC, for and hereby guarantee the payment of all facility charges incurred for my treatment in accordance with the orders of my prescribing or consulting physician(s), including any facility charge not paid, for any reason, by any payer or insurance company. I further agree that payment is due in full within 60 days of my discharge. If a balance cannot be paid in full after 60 days of my discharge, I agree to a payments schedule of $40.00 per month if my balance is $1.00 to $499.00, of 70.00 per month if my balance is $500.00 to $999.00, of $100.00 per month if my balance is greater than $1,000.00.

I understand that I am ultimately responsible for payment of any and all charges for medical services rendered by Cypress Physical Therapy, LLC, and if this assignment is rejected, modified, or not paid within a reasonable time after it has been filed, it will be my responsibility to pay any unpaid charges in full. If it is necessary to collect unpaid fees for services rendered, I agree to pay the charge assessed by the collection service, legal counsel, or court.

____________________________________ ____________________

Signature of Patient/ Parent/ Legal Guardian Date

____________________________________ ____________________

Facility Representative Date