CoreCare
physical therapy & wellness, llc

PATIENT REGISTRATION FORM

Personal Information

Last Name	**First Name**	**MI**
Preferred Name/Nickname	**Date of Birth**	
Address		
City	**State**	**Zip Code**
Mobile Phone	**Email Address**	
Home Phone	**Work Phone**	**Sex** ☐ M ☐ F / **Status** ☐ Singe ☐ Married ☐ Other
Injury/Onset Date	**Surgery Date** *(if applicable)*	**Body Part(s)**
Referring Physician	**Phone**	

Emergency Contact Information

Contact Name	**Phone**	**Relationship**

Insurance Information

Primary Insurance	**Secondary Insurance**
Insurance/Plan Name	**Insurance/Plan Name**
Policy ID #	**Policy ID #**
Group #	**Group #**
Patient relationship to policy holder ☐ **Self** ☐ **Spouse** ☐ **Child**	**Patient relationship to policy holder** ☐ **Self** ☐ **Spouse** ☐ **Child**
Name of Policy Holder *(if other than patient)*	**Name of Policy Holder** *(if other than patient)*

Appointment Reminders

Would you like appointment reminder? ☐ **YES** ☐ **NO** *If yes, please check* ☐ **Email** ☐ **Text** ☐ **Voice Call**

Consent to Treatment

- I give my authorization and consent for treatment and care after having a full explanation of proposed treatments, alternatives, and risks by my physical therapist.(history, physical examination, treatment, etc.)
- I realize I have the right to refuse any treatments or procedures to the extent permitted by law. I acknowledge that the delivery of health care does not guarantee results of any treatments at this facility. I understand that information from any medical record(s) kept by this facility may be used for educational, administrative, and/or facility approved purposes when my personal identity will not be revealed.
- I hereby authorize the release of medical information necessary to process my insurance and authorize payment directly to the provider of service. I am responsible for any services not covered by this authorization and fully understand the Patient Financial Responsibilities Form.
- Worker's Compensation - I hereby authorize CoreCare Physical Therapy to receive/release my records related to my work injury.

Patient Signature_____**Date**_____

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Photo/Video Authorization

I grant to CoreCare Physical Therapy and its affiliated entities, and its representatives and employees (collectively the "Company") the right to take photographs and\or videos of me in connection with my participation in physical therapy services. I authorize the Company, to copyright, use and publish the same in print and/or electronically. I agree that the Company may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content and waive any right to compensation therefore. I understand that I may revoke this authorization but only **in writing** delivered to the clinic office manager. I understand that if I choose to revoke this Authorization, the revocation will not be effective for any uses and/or disclosures of my protected health information that have already been made in reliance on this Authorization. ☐ **Agree or** ☐ **Decline**

Patient Financial Responsibility

I acknowledge that my physical therapy benefits have been explained to me to my satisfaction. I understand that I am ultimately responsible for any co-pays, deductible(s), out-of-pocket and/or co-insurance. I acknowledge that I should contact a representative of CoreCare Physical Therapy if I do not understand my benefits, have questions regarding payment due, or if I am unable to provide payment for my services prior to receiving treatment.

In the unlikely event your account would be turned over to a collection agency you would be responsible for all filing, collection, and legal fees necessary to obtain full recovery of any unpaid balance due to CoreCare Physical Therapy. There will also be interest added to invoices with balances over 30 days. **Returned Checks:** Non-Sufficient Funds - are subject to a **$30 fee** (in addition to bank fees)

I agree to allow CoreCare Physical Therapy to file my Health Insurance should my worker's compensation, auto, or third party insurance deny the claim, exhaust the benefits, or fail in any want to pay the claim.

I understand that failure to cancel or re-schedule my **appointment** 24 hours prior to my scheduled **appointment** time, will result in a **missed appointment/NO-Show fee** charged to my account. **($50** for a weekday appointment and **$100** for a Saturday appointment.**)**

If you are more than 15 minutes late for your appointment, it will be rescheduled and a late cancellation fee will be applied to your account. If you are aware that you are going to be late, please call the office and let us know. All decisions for treatment will be at your Therapists discretion. ☐ **Agree or** ☐ **Decline**

Notice of Privacy Practices

By signing this form, I acknowledge that CoreCare Physical Therapy has made its' Privacy Notice available to me, which explains how my health information will be handled in various situations. I understand that I may discuss my concerns and/or any questions I have concerning this Privacy Notice with CoreCare Physical Therapy representatives.

Authorization

I acknowledge, as indicated by my signature below, that I have read and fully understand this form. I am acknowledging my understanding of the "Notice of Privacy Practices" and authorizing persons listed on the Information Release to receive my health information.

Patient Signature: _____ **Date:** _____

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Medical History/ Questionnaire **Today's Date**_____

Name_____**D.O.B.**_____**Height/Weight:** _____

Referring Physician:_____**Date of next physician's visit**: _____

Chief Complaints: (What problems are you having?)_____

Date of injury/ when pain started?_____**Date of surgery (if applicable):** _____

Have you had physical therapy or chiropractic treatment this year? Y N If yes, where:_____

Do you smoke? Y N If so, how many packs/day?_____**Do you drink alcohol? Y N How much?** _____

Do you regularly exercise? Y N

Do you have any drug allergies: Y N Please specify _____

Please list your current medications: Additional pages are available at front desk

Name of Medication	Dosage	Directions	Date Stopped	Reason/ Doctor who prescribed

Have you ever had the following (circle yes or no, leave blank if uncertain)

Anemia	Y	N	Dizziness or Fainting Spells	Y	N	Pacemaker	Y	N
Arteriosclerosis	Y	N	Epilepsy	Y	N	Phlebitis	Y	N
Arthritis	Y	N	Gastrointestinal problems	Y	N	Pneumonia/Respiratory problems	Y	N
Asthma/Emphysema	Y	N	Heart disease	Y	N	Pregnant currently	Y	N
Back/Neck Trouble	Y	N	Hernia	Y	N	Skin Disease/Rashes	Y	N
Bleeding Tendency	Y	N	High or Low Blood Pressure	Y	N	Stroke	Y	N
Blood Clots	Y	N	Incontinence	Y	N	Thyroid Disease	Y	N
Cancer	Y	N	Kidney Disease	Y	N			
Circulatory Condition	Y	N	Metal Implants	Y	N			
Depression	Y	N	Migraines	Y	N			
Diabetes	Y	N	Mitral Valve Prolapse	Y	N			

If you answered yes to any of the items above, please briefly explain and give the date. Include pertinent information regarding your past medical history:

_____

_____

Previous surgeries (Please state the year and what illness/surgery you had)

Date/Year	Illness/Operation	Date/Year	Illness/Operation

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Pain and Symptoms (Circle the best possible answer):

Is your pain? Occasional Continuous Constant Intermittent Unrelenting

Symptom trend: Condition improving Condition worsening Condition unchanging

When is your pain the worst? Morning Afternoon Evening Nighttime

When is your pain the best? Morning Afternoon Evening Nighttime

Does the pain affect your sleep? YES NO

Circle the number the rates your pain *right now*:

None 1 2 3 4 5 6 7 8 9 10 Worst Pain

Circle the number that rates your pain *at worst*:

None 1 2 3 4 5 6 7 8 9 10 Worst Pain

Circle the number that rates your pain *at best*:

None 1 2 3 4 5 6 7 8 9 10 Worst Pain

Please describe:

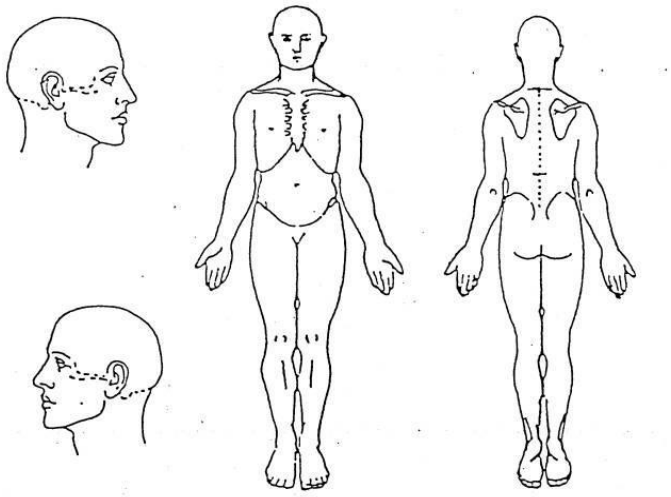
What makes your pain better?_____

What makes your pain worse?_____

Due to my symptoms/disease I am unable to/have difficulty with _____

My goal(s) for therapy:_____

Please indicate below where your symptoms are located



KEY	
Numbness	= = = = = =
Pins & Needles	*******
Burning Pain	BBBBBBB
Stabbing Pain	///////
Shooting Pain	XXXXXXX
Achy Pain	AAAAAAA

My signature below confirms that this medical history is accurate to the best of my knowledge:

_____ _____

(Patient or guardian signature) **(Date)**