CALDWELL PHYSICAL THERAPY AND SPORTS REHABILITATION REGISTRATION

Patient Name: _____ Date of Birth: _____

Address: _____ Apt. #_____

City: _____State:_____Zip:_____

Sex: ☐ M ☐ F Email Address: _____

Home Phone #: _____Work/Cell Phone #: _____

Who is the physician treating you for this problem? _____

Whom may we thank for kindly referring you to our office? _____

In Case of Emergency: _____Phone #: _____Relationship: _____

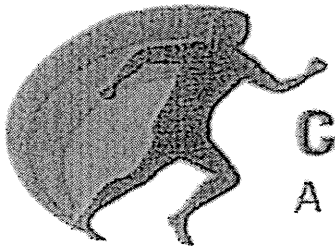
Have you had PT, OT, Speech, Chiro, Acupuncture this year? ☐ Y ☐ N

How many visits? _____

If you are a Medicare patient, are you enrolled in Home Health? ☐ Y ☐ N

Please list all current medications you are taking:

	Medication:	**Medical Reason:**
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____



CALDWELL PHYSICAL THERAPY
AND SPORTS REHABILITATION

For your safety and the safety of others please respond to the following questions prior to receiving your first initial visit.

1. Have you traveled outside the United States in the 14 days?
   ☐ Yes ☐ No
2. Have you had any of the following symptoms in the last 14 days?
   - Cough
     ☐ Yes ☐ No
   - Fever: ***Please note we will take your temperature prior to your treatment***
     ☐ Yes ☐ No
   - Chills
     ☐ Yes ☐ No
   - Difficulty breathing
     ☐ Yes ☐ No
3. Have you been exposed to someone diagnosed with COVID-19 within the last 14 days? If "yes," since exposure, have you been tested for COVID-19?
   ☐ Yes ☐ No Date _____
4. Have you been diagnosed with COVID-19? If "yes," have you been cleared of it since testing positive?
   ☐ Yes ☐ No Date _____
5. If answered "yes" to any of the above: Have you discussed these symptoms with your physician?
   ☐ Yes ☐ No Date _____ Physician _____

Despite best practices and changing guidelines, I acknowledge that by participating in physical therapy , inherent risk may be present involving COVID19.
Should my above status change at any time during my treatment, I will inform the Caldwell Physical Therapy staff immediately.

Signature_____ Date_____

2021

PATIENT INFORMATION ACKNOWLEDGMENT FORM

COMPANY NAME: Caldwell Physical Therapy

I have read and fully understand above named practice's Notice of Information Practices. I understand that above named practice may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that above named practice will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in above named practice's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____
Patient Name

_____
Signature

_____

Date

I also authorize above named practice to use my protected health information for targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

_____
Patient Name

_____
Signature

_____
Date

2021 Patient Signature

COMPANY NAME: Caldwell Physical Therapy

PATIENT NAME: _____

____ *Consent for Care and Treatment*

I, the undersigned, hereby agree and give my consent for above named practice to furnish care and treatment considered necessary and proper in treating my condition.

____ *Authorization for Signature on File and Release of Information*

I, the undersigned, hereby authorize the office of above named practice to affix my name to any and all claims or documents as related to any and all health benefits due me. I authorize the release of any information relating to my health care claims. A photostatted copy of this authorization shall be as valid as an original.

____ *Authorization for Assignment of Benefits*

I, the undersigned, hereby assign all medical benefits, to which I am entitled, to the office of above named practice, and I shall be financially responsible for any unpaid balance. In the event payment is made directly to me for services rendered by this office, I recognize the obligation to promptly remit payment to this office. I hereby authorize and instruct my insurance company to pay by check and mail directly to above named practice.

____ *Financial Responsibility*

I, the undersigned, understand and agree that if it becomes necessary to commence legal action, I am responsible for all costs of collecting moneys owed including court costs, collection agency fees and attorney fees, in addition to my outstanding account balance. I further understand that balances over 60 days will be subject to a 1.5% finance charge, for which I am personally liable.

____ *Cancellation Policy*

Specific time is reserved for you when you schedule an appointment. If you cannot keep your scheduled appointment, please give us at least 24 hours notice so that we may reschedule your appointment and offer the reserved time to another patient. There will be a charge of $50.00 for NO SHOW appointments or cancellations with less than 24-hour notification. I, the undersigned, understand that I will be personally responsible for any cancellation fees.

____ *Reminder Message*

I, the undersigned, hereby authorize the office of above named practice to send reminders to my mobile number, home phone, or email address of upcoming appointments.

I have read and fully understand all of the above information and hereby agree to comply as outlined above.

_____ _____

Patient or Guardian Signature Date

2021
DESIGNATED INDIVIDUALS AUTHORIZATION FORM

Company Name:_____

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

_____
Patient Name

_____
Patient Signature

_____
Date