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**Patient Registration Form - Medicare**

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| Patient Name: Preferred Name: | |
| Address, City, State, Zip: | |
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| DOB: Social Security #: | |
| Email Address: | |
| Home Phone: | Appointment Reminder Method |
| Cell Phone: | □ Home Phone □ Cell Phone |
| Work Phone: | □ Work Phone □ Email |

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| Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Partner's Name: |
| Financial Responsibility: ☐ Self ☐ Other, Please List: |
| 2nd Contact Name/Address: |
| 2nd Contact Phone: Relation: |
| General Physician: Referred By: |

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| Have you had Physical Therapy treatment since January of this year? ☐ Yes ☐ No If yes, # of Visits: |
| Have you had Chiropractic treatment since January of this year? ☐ Yes ☐ No If yes, # of Visits: |
| Have you had Home Healthcare in the last 30 days? ☐ Yes ☐ No  If yes, Home Healthcare Provider: |

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| **INSURANCE INFORMATION** Please Note: A copy of your insurance card(s) will be kept on file. The patient is responsible to provide their most current insurance information. | | | |
| Primary Insurance: | | Secondary Insurance: | |
| Group # | Policy # | Group # | Policy # |
| Insured Information: | | Insured Information: | |
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| **Consent to Treat/Assignment of Benefits/Acknowledgements** |
| I hereby authorize and consent to treatment/services for myself, or on the behalf of the above-named patient performed by the staff at Peak Physical Therapy and/or as directed by my referring provider. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including risk or alternatives to the recommended treatment plan.  I assign payment for these services directly to Peak Physical Therapy. I authorize the filing of claims to my insurance plan and authorize Peak Physical Therapy to release necessary health information related to these services to process the claims. I certify that the information I have provided is accurate and complete.  In signing this form, I will promptly pay any required co-pay, coinsurance and/or deductible amounts. I accept that insurance plans may deny payments for what I believed were covered services, resulting in my responsibility for paying for these services.  I acknowledge that I have received the Notice of Privacy Practices, which describes the ways the practice may use or disclose my healthcare information. I understand that my healthcare information may be used for treatment, payment, healthcare operations and other permitted uses or disclosures as described in the Notice.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Patient/Guardian Date  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Print Name and Relationship to the Patient |

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| **Patient name:** |
| **Authorization for Communication** |
| By providing my above contact information and signing below, I consent and authorize Peak Physical Therapy and its related entities, agents, contractors, including but not limited to scheduling, billing, marketing and other departments to use automated telephone dialing systems, SMS text messaging, and electronic mail to (1) provide messages (including prerecorded messages or text messages) to me about appointment reminders, patient surveys, my account, payment due dates, missed payments, information for or related to medical goods and/or therapy services provided, exchange information, changes to health care law, health care coverage, care follow-up, and other healthcare information or (2) provide messages (including pre-recorded messages) during a call or via text message that delivers a ‘health care’ message made by, or on behalf of, a ‘covered entity’ or its ‘business associate’ as those terms are defined in the HIPAA Privacy Rule, 45 CFR 160.103. I understand that providing a telephone number and/or email address is not a condition of receiving medical services.  I also understand that I may revoke my consent to contact at any time by directly contacting Peak Physical Therapy or using the opt-out method that will be identified in the applicable communication. I also understand that it is my responsibility to notify Peak Physical Therapy immediately of any change in telephone number or email address.  Patient/Guardian Signature: Date: |

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| **Release of Information** |
| I hereby authorized Peak Physical Therapy to discuss my personal healthcare information regarding my treatment including diagnosis/prognosis and/or billing and payment for services rendered on my behalf to the person(s) listed below.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name (print) Relationship Phone number  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name (print) Relationship Phone number  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name (print) Relationship Phone number  Patient/Guardian Signature: Date: |

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| **Financial Policy** |
| **Cancellation/No Show**  Successful therapy is dependent on a strong working relationship between the patient and the therapist. Maximum progress and success are made when the patient is an active participant in their home exercise program and attends all appointments.  Peak Physical Therapy requires 24-hour notice for ALL cancellations. There may be a fee assessed which is not covered by insurance and would be an out-of-pocket expense for cancellations without proper notice.  If a cancellation is unavoidable, we do ask that you give us as much notice as possible so we may offer that appointment time to another patient.   * If you arrive later than 15 minutes after your scheduled appointment time, we may ask you to reschedule. * After more than one cancellation or no show, we require that you call the day of for an appointment. * 2 “no show” appointments may result in discharge from therapy.   **Copays are due at the time services are rendered.**  We will verify your benefits with your insurance carrier. However, this does not guarantee that they will cover the prescribed treatment. By signing below, you are acknowledging that you are responsible for deductibles, copays, coinsurance, and non-covered services not paid by the insurance carrier and understand that you are fully responsible for any balance due for services rendered.  Patient/Guardian Signature: Date: |

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| **MEDICARE SECONDARY PAYER (MSP) FORM** | | | | |
| **Patient Name:** | | | | |
| **Part I** | | | | |
| 1. Are you receiving benefits under the Black Lung Program?   If yes, date benefits began: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | * Yes | * No | |
| 1. Was this injury/illness due to a work-related accident/condition?   If yes, date of injury/illness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | * Yes | * No | |
| 1. Was the injury/illness covered under no-fault (and/or medical-payment coverage) including premises or automobile?   If yes, date of accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Is no-fault insurance available? | | * Yes * Yes | * No * No | |
| 1. Was this injury/illness related to an accident in which you intend to file liability suit or litigation pending?   If yes, please provide:  Attorney’s Name: \_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_  Phone Number: \_\_\_\_\_\_\_\_\_  If you answered **NO** to all questions, go to Part II.  If you answered **YES** to any of the questions above, Medicare is the secondary payer, you do not need to go to Part II. Please provide primary insurance information. | | * Yes | * No | |
| **Part II** | | | | |
| 1. Are you entitled to Medicare based on? *Check the box that applies.*   ☐ Age (65 & older) – go to question #2  ☐ Disability – go to question #2  ☐ End Stage – Go to **Part III** | | | | |
| 1. Do you have group health plan (GHP) coverage based on your own current employment, or the current employment of either your spouse or another family member?   If yes, based upon if you are 65 & over or disabled, how many employees, including yourself or spouse, work for the employer from whom you have GHP coverage:   * + Aged (65 & over) - If you are aged and there are 20 or more employees, your GHP is primary.   + Disability - If you are disabled and your employer, spouse, or family members employer, has 100 or more employees, your GHP is primary. | | * Yes * Yes * Yes | * No * No * No | |
| **Part III** | | | | |
| *Medicare benefits are secondary to benefits payable under a GHP for individuals eligible for or entitled to benefits on the basis of ESRD during a period of up to 30-month period if Medicare was not the proper primary payer for the individual on the basis of age or disability at the time that this individual became eligible or entitled to Medicare on the basis of ESRD****.*** | | | | |
| 1. Do you have group health plan coverage? | | * Yes | | * No |
| 1. Are you within the 30-month coordination period? | | * Yes | | * No |
| If yes to BOTH questions, GHP is primary during the 30-month coordination period. | | | | |
| ***Please provide a copy of your group health insurance if determined to be primary.*** | | | | |
| Signature of Patient/Representative: | Date: | | | |
| Relationship to Patient: | | | | |

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| **PATIENT HEALTH QUESTIONNAIRE** |
| **Patient Name: Preferred Name:** |
| Occupation: Height: Weight: |
| How many times have you fallen in the past 12 months? Did it result in an injury? ☐ Yes ☐ No |
| During the past month have you been feeling down, depressed, hopeless, or bothered by having little interest or pleasure in doing things? ☐ Yes ☐ No |
| General Health Status: Please rate your health. □ Excellent □ Good □ Fair □ Poor |
| Please list any known allergies (including medications, latex, etc.) below. |
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| **Current Condition** |
| When did this problem(s) first begin/date of onset?  If chronic, when did you seek medical treatment? |
| Is your current condition related to recent surgery? ☐ Yes ☐ No If yes, specify the date of surgery: |
| Describe the problem(s). |
|  |
| Explain how the problem(s) occurred. |
|  |
| Have you ever had this problem before? ☐ Yes ☐ No If yes, how many times? |
| Are your symptoms worse in the: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Same All Day |
| How are you taking care of the problem(s) now? |
| My pain/problem is slowly getting: ☐ Worse ☐ Better ☐ Staying the Same |
| My symptoms bother me: ☐ Constantly (100%) ☐ Most of the Time (75%)  ☐ Occasionally (50%) ☐ Once in a While (25%) |
| Do you have any numbness, tingling, or burning? ☐ Yes ☐ No  If yes, please check one: ☐ Constantly ☐ Intermittently |
| What functions could you perform before, that you now are unable to do? |
|  |
| Please explain any specific treatment you have received for this problem, such as previous physical or occupational therapy, chiropractic visits, pain medications, etc. |
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| Have you received X-rays, MRI, CT scan, or Bone scan for this problem? If so, please list the dates and results. |
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| Are you aware of any physical reason why you should not receive treatment? ☐ Yes ☐ No  If yes, please tell us what it is: |
| What are your goals for therapy? |
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| **Patient Name:** | |
| **Surgery / Hospitalization, please include the date and reason.** | |
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| **Please list current medications** (including prescription, over-the-counter, and herbal). You can also provide our office staff with a list to copy. | | | |
| Name | Dosage | Frequency | Please Indicate Route |
|  |  |  | Oral Patch Topical Other |
|  |  |  | Oral Patch Topical Other |
|  |  |  | Oral Patch Topical Other |
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|  |  |  | Oral Patch Topical Other |

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| **Are you currently experiencing any of the following?** | | | |
| Nausea or Vomiting | ☐ Yes ☐ No | Chest Pains (Angina) | ☐ Yes ☐ No |
| Productive/Chronic Cough | ☐ Yes ☐ No | Pain Wakes Me at Night | ☐ Yes ☐ No |
| Difficulty Swallowing | ☐ Yes ☐ No | Recent Fever, Chills, Sweats | ☐ Yes ☐ No |
| Dizzy Spells | ☐ Yes ☐ No | Difficulty Sleeping | ☐ Yes ☐ No |
| Headaches | ☐ Yes ☐ No | Shortness of Breath | ☐ Yes ☐ No |
| Visual Problems | ☐ Yes ☐ No | Heart Palpitations | ☐ Yes ☐ No |
| Hearing Loss/Ringing in Ears | ☐ Yes ☐ No | Loss of Appetite | ☐ Yes ☐ No |
| Difficulty Walking | ☐ Yes ☐ No | Incontinence | ☐ Yes ☐ No |
| Unusual Weakness | ☐ Yes ☐ No | Fatigue or Myalgia | ☐ Yes ☐ No |
| Joint Pain or Swelling | ☐ Yes ☐ No | Unexplained Weight Changes | ☐ Yes ☐ No |

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| **Social History / Wellness** | |
| Do you drink alcoholic beverages? ☐ Yes ☐ No | Do you use tobacco? ☐ Yes ☐ No |
| How often have you completed at least 20 minutes of exercise, such as jogging, cycling, or brisk walking, before the onset of your condition? ☐ At least 3 times per week ☐ 1-2 times per week ☐ Seldom or Never | |

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| **Have you been diagnosed with any of the following?** | | | |
| Allergies | * Yes ☐ No | High Blood Pressure | * Yes ☐ No |
| Anemia | * Yes ☐ No | HIV | * Yes ☐ No |
| Hepatitis, If Yes, Type: | * Yes ☐ No | Tuberculosis | * Yes ☐ No |
| Respiratory Problems | * Yes ☐ No | Kidney Disease/Problems | * Yes ☐ No |
| Auto-Immune Disease  If yes, Type: | * Yes ☐ No | Spinal Cord Stimulator | * Yes ☐ No |
| Blood Clots | * Yes ☐ No | Vision Problems | * Yes ☐ No |
| Bowel or Bladder Disorder | * Yes ☐ No | Osteoporosis | * Yes ☐ No |
| Cancer, If yes, Site: | * Yes ☐ No | Rheumatoid Arthritis | * Yes ☐ No |
| Cardiac Conditions | * Yes ☐ No | Parkinson’s | * Yes ☐ No |
| Cardiac Pacemaker | * Yes ☐ No | Peripheral Vascular Disease | * Yes ☐ No |
| Currently Pregnant | * Yes ☐ No | Seizures | * Yes ☐ No |
| Depression | * Yes ☐ No | Speech Problems | * Yes ☐ No |
| Diabetes | * Yes ☐ No | Hearing Loss | * Yes ☐ No |
| Stroke/TIA | * Yes ☐ No | Fractures | * Yes ☐ No |

**I will advise the therapist if there is any change in my physical condition which will alter my response to any of the questions on this form.**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_