

ActivBody Physical Therapy

Patient Registration Form

Date: / /

Primary Insurance: Medicare <input type="checkbox"/> Group Health <input type="checkbox"/> Workers Comp <input type="checkbox"/> Lien <input type="checkbox"/> Other <input type="checkbox"/>				Secondary Insurance: Medicare <input type="checkbox"/> Group Health <input type="checkbox"/> Workers Comp <input type="checkbox"/> Lien <input type="checkbox"/> Other <input type="checkbox"/>			
Patient #	Title	Patient Name (Last, First, Middle Initial)					
Address			City/State/Zip				
Home Phone () -		Work Phone () - Ext:		Email Address			
Social Security # - -	DOB / /	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Driver's License #	Financial Class			
Referring Physician		UPIN	Referring Physician Phone # () -	Treating Therapist			
Patient Status <input type="checkbox"/> Active <input type="checkbox"/> SFA	Primary Location CLINIC	Marital Status	Student		Employment Status		
Occupation		Employer		Employer Phone # () -			
Address			City/State/Zip				

Emergency Contact (Name)	Home Phone () -	Work Phone () -
Address	City/State/Zip	Relationship to Patient

Financially Responsible Party Other than Patient

Name (First, Middle Initial, Last)		Relationship to Patient
Address		City/State/Zip
Home Phone () -	Work Phone () -	Email Address
Social Security # - -	DOB / /	Gender <input type="checkbox"/> M <input type="checkbox"/> F
		Driver's License #

Injury Information

Is condition surgery related? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Surgery / /	Surgical Procedure
Is the condition accident related? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was an automobile involved? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Accident / /
Describe Accident		
Were you injured on the job? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Injury / /	Are you currently working? <input type="checkbox"/> Yes <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> No
Name of employer at the time of accident		City, State, Zip Code
Describe Injury		
Is litigation involved? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Attorney	Phone # () -

-Office Use Only-

Diagnosis:	ICD-9 Code:
Diagnosis:	ICD-9 Code:
Diagnosis:	ICD-9 Code:

Insurance Information

Were benefits and authorizations verified? Yes No

Primary Insurance: In-network <input type="checkbox"/> Out-of-network <input type="checkbox"/>		Pre-Certification <input type="checkbox"/> Yes <input type="checkbox"/> No		Visits per Year	
Claims Mailing Address		City/State/Zip			
Subscriber Name	DOB / /	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to Patient		
ID Card #(including alpha prefix)		Group #		Authorization #	
Claim #	Effective Date	Coverage%	Co-Ins%	Co-Pay by Specialty \$	Visits Remaining
Deductible Start Amount \$		Deductible Remaining Amount \$		Pre-Certification Phone # () -	
Benefits Verified By	Date / /	Spoke to		Ins. Customer Service Phone # () -	

Secondary Insurance:					In-network <input type="checkbox"/> Out-of-network <input type="checkbox"/>	
Claims Mailing Address		City/State/Zip				
Subscriber Name	DOB / /	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to Patient			
ID Card #(including alpha prefix)		Group #		Authorization #		
Claim #	Effective Date	Coverage%	Co-Ins%	Co-Pay \$	Pre-Certification <input type="checkbox"/> Yes <input type="checkbox"/> No	Visits per year
Deductible Start Amount \$		Deductible Remaining Amount \$		Pre-Certification Phone # () -		
Benefits Verified By	Date / /	Spoke to		Ins. Customer Service Phone # () -		

The above description is a quote of your insurance(s) benefits. We assume no liability for any errors made by your insurance carrier(s) in this quotation. It is your responsibility to clarify any discrepancies in eligibility, benefits and/or authorization and inform our clinic immediately. We have reviewed these benefits with you. You understand and agree to pay any balance remaining after your insurance carrier(s) has paid its portion of charges.

	/ /		/ /
Patient Initials	Date	Front Office	Date

ASSIGNMENT OF INSURANCE BENEFITS

1. The undersigned agrees, whether signing as agent or patient, and it hereby individually obligated to pay for services rendered to the patient in accordance with regular rates and terms of the company, which are not reimbursed by third parties. The undersigned further agrees to bear legal fees and collection expenses, which may be incurred by the company, in collection of payment amount, if that amount becomes delinquent.
2. The undersigned hereby authorizes treatment by ActivBody Physical Therapy and assigns to ActivBody Physical Therapy any and all benefits arising out of any type of insurance, which insures the patient's bill. The undersigned understands that the temporary acceptance of verified insurance coverage in lieu of payment does not release the patient from ultimate payment responsibilities.
3. The undersigned hereby authorizes ActivBody Physical Therapy to release and or all information to third parties, including but not limited to employers and insurance companies, who may be liable to the patient or ActivBody Physical Therapy for payment of charges to the patient.
4. ActivBody Physical Therapy reserves the right to modify the privacy practices outlined in the notices. The undersigned acknowledges having received a copy of the Notice of Privacy Practices for ActivBody Physical Therapy.

Patient Signature:	Date / /
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CPM Office Use Only:	Entered by:	Date / /
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MEDICAL HISTORY

Have you had any of the following?

	Yes	No		Yes	No
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Conditions	<input type="checkbox"/>	<input type="checkbox"/>	Liver Conditions	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Circulation Issues	<input type="checkbox"/>	<input type="checkbox"/>	Claustrophobia	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>
Dizzy Spells	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to Heat	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to Cold	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Speech Problems	<input type="checkbox"/>	<input type="checkbox"/>
Fractures	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Metal Implants	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>			

Any other conditions or illnesses? No Yes Please explain: _____

List any surgeries with their dates you have had: _____

Medications you are currently taking: _____

Have you ever had Physical Therapy? No Yes Please list when, for what condition, and where? _____

How did you hear about ActivBody PT (i.e. Doctor, Sign, Web Search, Yellow Pages, Friend, other)? _____

Check any other areas you would like to seek advice on:

- | | | |
|--|--|--|
| <input type="checkbox"/> Body Fat Loss | <input type="checkbox"/> Nutritional Supplementation | <input type="checkbox"/> Immune System Support |
| <input type="checkbox"/> Joint Health | <input type="checkbox"/> Cardiac Health/Cholesterol Issues | <input type="checkbox"/> Anti-Oxidants |