

## PATIENT REGISTRATION INFORMATION (PAGE 1)

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient Name \_\_\_\_\_

(Last)

(First)

(Middle)

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Numbers: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender  M  F

Soc. Sec. # \_\_\_\_\_ Marital Status  M  S  D  W

E-Mail Address \_\_\_\_\_

Referring Physician \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_

Daytime Phone Number \_\_\_\_\_ Cell #: ( ) \_\_\_\_\_

What injury/ailment are we treating today? \_\_\_\_\_

Date of injury or onset of symptoms? \_\_\_\_\_

How did your injury occur? \_\_\_\_\_

Who referred you to our practice? \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Follow-up appointment scheduled for \_\_\_\_\_

Have you seen a physical, occupational, or speech therapist this year?  Yes  No

If yes, where did you go? \_\_\_\_\_ How long in therapy? \_\_\_\_\_

## PATIENT REGISTRATION INFORMATION (PAGE 2)

Are you currently taking any medication? If so, list. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you allergic to any drugs/medications? If so, please list. \_\_\_\_\_

\_\_\_\_\_

Who would assist us in your care: \_\_\_\_\_

Please check any of the following that you now have or that may be related to your current condition:

- |                                                          |                                                         |
|----------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Allergies                       | <input type="checkbox"/> High Blood Pressure            |
| <input type="checkbox"/> Anemia                          | <input type="checkbox"/> Hip Injury/Surgery             |
| <input type="checkbox"/> Any Pins or Metal Implants      | <input type="checkbox"/> Infectious Diseases            |
| <input type="checkbox"/> Arthritis/Swollen Joints        | <input type="checkbox"/> Joint Replacement              |
| <input type="checkbox"/> Asthma/Bronchitis/Emphysema     | <input type="checkbox"/> Knee Injury/Surgery            |
| <input type="checkbox"/> Back Injury/Surgery             | <input type="checkbox"/> Neck Injury/Surgery            |
| <input type="checkbox"/> Blood Clot/Emboli               | <input type="checkbox"/> Numbness or Tingling           |
| <input type="checkbox"/> Bowel or Bladder Problems       | <input type="checkbox"/> Osteoporosis                   |
| <input type="checkbox"/> Cancer/Chemo/Radiation          | <input type="checkbox"/> Pacemaker                      |
| <input type="checkbox"/> Coronary Heart Disease/Angina   | <input type="checkbox"/> Pregnant currently             |
| <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Severe or Frequent Headaches   |
| <input type="checkbox"/> Dizziness or Fainting           | <input type="checkbox"/> Shortness of Breath/Chest Pain |
| <input type="checkbox"/> Elbow Injury/Surgery            | <input type="checkbox"/> Shoulder Injury/Surgery        |
| <input type="checkbox"/> Emotional/Psychological Problem | <input type="checkbox"/> Sleeping Problems              |
| <input type="checkbox"/> Epilepsy/Seizures               | <input type="checkbox"/> Stroke/TIA                     |
| <input type="checkbox"/> Foot/Ankle Injury/Surgery       | <input type="checkbox"/> Thyroid Trouble/Goiter         |
| <input type="checkbox"/> Gout                            | <input type="checkbox"/> Varicose Veins                 |
| <input type="checkbox"/> Hand/Wrist Injury/Surgery       | <input type="checkbox"/> Vision or Hearing Difficulties |
| <input type="checkbox"/> Heart Attack or Heart Surgery   | <input type="checkbox"/> Weakness                       |
| <input type="checkbox"/> Hernia                          | <input type="checkbox"/> Weight Loss/Energy Loss        |

Surgery in the last 12 months? Give details.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## POLICIES OF ALLIED REHAB

### Treatment Consent

I consent to therapy considered necessary in diagnosing and/or treating my condition.

### Authorization and Release

I authorize Allied Rehab to bill and receive payments from my insurance company. I also permit the release of necessary information, including medical records, to my insurance company.

### Financial Policy

Payment of all co-pays, deductibles and any portion not covered by my insurance company is due at time of service. ALLIED REHAB WILL BILL MY INSURANCE CARRIER AS A COURTESY TO ME. Allied Rehab CANNOT guarantee insurance benefits given by the insurance company to be 100% accurate. The information Allied Rehab receives IS NOT A GUARANTEE of payment from the insurance company. It is recommended that I call and verify benefits prior to my scheduled appointment. I understand that I am responsible for any portion not covered by my insurance company and prompt payment is required. An 8% interest fee will incur on any balance greater than 30 days. Accounts sent to collections will incur additional fees

### No-Show Policy

It is important that I keep all scheduled appointments to obtain maximum benefit from my rehabilitation program. Being on time for these appointments is IMPERATIVE! The therapist has blocked this time especially for me. Not showing or giving less than 24 hrs notice to cancel, takes time away from other patients who would have benefited from this appointment. A \$50 fee will be charged to my account for a no-show or late cancellation.

PLEASE INITIAL FEE NOTICE OF \$50.00 \_\_\_\_\_

I have read, understood and accepted the above policies as indicated by my signature below.

Name: \_\_\_\_\_

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

Witness: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Signature of Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness