



New Patient Registration
Personal Information

Last Name: _____
First Name: _____
Address: _____
City: _____ State _____ Zip _____
Home #: () _____ Work: () _____
Cell #: () _____ Fax: () _____
email: _____
SS #: _____ - _____ - _____
Sex: F M Date of Birth: _____
Referring Physician: _____

Employment Information

Employer: _____
Employer Address: _____
Responsible Party: _____
Address: _____

Insurance Information

Name of Insured: _____
SS # of Insured: _____
Relationship: _____
Insured's Date of Birth: _____
Insurance Carrier: _____
Policy #: _____

Contact person in case of emergency: _____
Phone: () _____

I authorize all payment of medical benefits directly to Thrive Integrated Physical Therapy, PC for all services rendered. I agree to be responsible for deductible and co-payment fees.

Signature: _____ Date: _____

Please Note: SCHEDULED APPOINTMENTS **MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE** OR A **\$75 LATE CANCEL CHARGE WILL BE ASSESSED**. SIMILARLY, IF YOU MISS A SCHEDULED APPOINTMENT, A **\$75 FEE WILL BE ASSESSED**. THIS FEE IS NOT BILLABLE TO YOUR INSURANCE.

I have read and understand this policy.

Signature: _____ Date: _____

Physical Therapy Patient History

Date:	Last Name:	First Name:	Age:	<input type="checkbox"/> Right-handed
				<input type="checkbox"/> Left-handed

Present Status

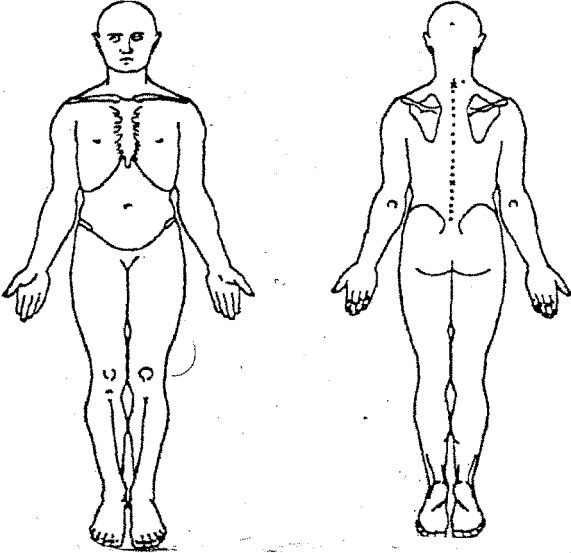
What is your chief complaint

Rate your chief complain in order of severity from 1 to 5, 1 being the least and 5 being most severe:

___Pain ___Loss of Motion ___Swelling ___Stiffness ___Loss of Function

When the did the problem begin (specify date if applicable):

How did the problem begin?

	<p style="text-align: center;">Where is the problem?</p> <p>Indicate where your symptoms are on the diagram to the left with the symbol indicating the type of pain or symptoms you are having.</p> <p>+ = Numbness/tingling</p> <p># = Pain</p> <p><> = Other _____</p>
--	--

What in particular makes your pain or symptoms worse?

What , if anything, eases your pain or symptoms

How are your symptoms in the morning?

How are your symptoms in the afternoon?

How are your symptoms at night (does your current problem interrupt your sleep?)

Has this problems affected your daily life (job, exercise, etc.,)?

Are your symptoms Improving Stable Worse

Have you had previous similar occurrences of these symptoms? Yes No

If yes, please describe:

Are there any other medical conditions that we should be aware of?

Present Status (cont'd)

What, if any, treatment have you had for this problem?

Physical Therapy Chiropractic Acupuncture Other _____

Did this treatment help? Yes No Explain please:

Have you had any special test (MRIs, x-rays, etc.,) and what were the results?

Medical History

Did your symptoms change with coughing or sneezing?..... yes no

Have you had any changes in bowel or bladder function or anesthesia in this area?..... yes no

Do you experience any dizziness or vertigo?..... yes no

Do you have bilateral tingling in hands and/or feet?..... yes no

Do you have any gait disturbance?..... yes no

Have you had any recent change in your weight or appetite?..... yes no

Do you have an intolerance to hot or cold?..... yes no

Do you have any bruising or bleeding disorders?..... yes no

Have you had any skin change, such as rash or discoloration?..... yes no

Have you any recent episodes of nausea or vomiting?..... yes no

Have you experienced any recent change in vision, such as blurred or double vision?..... yes no

Have you noticed any shortness of breath or change in exercise tolerance?..... yes no

Are you pregnant?..... yes no

Have you received extensive steroid therapy?..... yes no

Do you have any allergies?..... yes no

If yes, please specify _____

Do you have any cardiac problems?..... yes no

Do you have high blood pressure?..... yes no

Do you have diabetes?..... yes no

Do you have a history of cancer?..... yes no

Do you have osteoporosis?..... yes no

Do you have asthma?..... yes no

**Are there any other conditions or illnesses we should be away of?..... yes no

If yes, please specify: _____

List any past surgeries you have had:

List all medications you are presently taking:

Social history

What is your current occupation? Presently working? yes no

What is your activity level Sedentary Light Heavy Very Heavy

What type of sports do you participate I, if any?

Do you use tobacco? yes no Do you drink alcohol? yes no

Family History

Has any member of your family had high blood pressure, diabetes, cardiac problems or cancer

If yes, please explain:

Patient signature: _____

Date: _____

Physical Therapy Patient Agreement

Thank you for choosing Thrive Integrated Physical Therapy. Please read and sign the following agreement; it explains our billing, scheduling and cancellation policies. If you have any questions, we will be glad to answer them.

All patients of Thrive Integrated Physical Therapy must have a valid, written prescription from a medical doctor, osteopath or podiatrist. Patients are responsible for scheduling and confirming appointments with the front desk.

Payment of all fees is expected at time of service or via credit card on file. We will assist you in submitting claims to your insurance carrier. However, you are still responsible for any deductible, co-insurance/co-payments or claim denied by your insurance carrier. Should your account go into arrears, all attorney fees will be charged in addition to your outstanding balance.

I hereby authorize Thrive Integrated Physical Therapy, PC, having treated me, to release to government agencies, insurance carriers, and all others who are financially liable for my care, all information needed to substantiate payments for care and to permit representative thereof to examine and make copies of all records related to such care and treatment. I understand that if, at any point, my insurance coverage changes, I am to notify the staff prior to my next visit. Failure to do so will result in my being responsible for the full amount of services.

A scheduled appointment must be cancelled at least 24 hours in advance or a \$75 late cancel fee will be assessed. Similarly, if you do not show up for a scheduled appointment, a \$75 fee will be assessed. **This fee is not billable to any insurance carrier.** We reserve the right to remove you from the treatment schedule if you cancel without 24 hours notice or if you do not show up for your appointments **three consecutive times.**

Lockers are available for your use at your own risk. Thrive shall not be liable for the disappearance, loss, theft of, or damage to your personal property: this would include money, negotiable securities, furs or jewelry.

I have read, understand and agree to all the above policies and procedures.

Signature of patient or authorized representative



Credit Card on File Agreement

In order to expedite your billing through your commercial insurance carrier, we require that you make your co-payments on a per visit basis. Payment can be made by cash, check or credit card.

All patients are required to keep personal credit card information on file.

If you would like, Thrive will bill your account twice monthly for co-payments for the 1st through 15th, and again for the 16th through 31st. A paid invoice and copy of the receipt will be sent to you for your records.

In addition, any insurance policy deductibles will be charged against your credit card once we have been sent proper notification by your major medical insurance carrier. A paid invoice and copy of the receipt will be sent to you for your records.

If you attend Thrive on an out of network basis, we require that you send us insurance payment checks endorsed to Thrive, as well as the attached explanation of benefits ("EOBs") upon receipt. If we do not receive payment from you for services within two weeks of your having received payment from your insurer, we will bill your credit card for the full balance of the visit.

Name (please print)

Date

Credit Card: Please circle one

VISA

MASTERCARD

AMEX

DISCOVER

Card #: _____

Exp. Date

Signature on file: _____

Thank you for your attention in this matter.