VERNON PHYSICAL THERAPY

PATIENT REGISTRATION

PATIENT INFORMATION

Patient Name_____ Marital Status **S M D W**

Home Address _____

City_____ State _____ Zip _____

Social Security #_____ Birth Date ____/____/____ Sex_____

Phone: *check best method of contact*

☐ Home _____

☐ Cell _____

☐ Work _____

Email_____

☐ *check if you prefer to receive notifications via email*

Occupation_____

PERSON RESPONSIBLE FOR BILL ☐ SELF

Name_____ Phone _____

Home Address _____

City_____ State _____ Zip _____

Social Security #_____ Birth Date ____/____/____ Sex_____

EMERGENCY CONTACT

Name: _____ Phone:_____ Relationship:_____

REFERRING PHYSICIAN

Name _____ Office Location _____

Diagnosis and/or description of problem _____

How did you hear about Vernon Physical Therapy? *(check all that apply)*

☐ Physician
☐ Friend/Relative
☐ Internet
☐ Insurance
☐ Other

AUTHORIZATION & CONSENT

- I authorize the release of any applicable private health information necessary to process a claim
- I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable. I also understand that Vernon Physical Therapy, P.C. may use my patient treatment data for quality assurance and research purposes, and that my personal information will not be associated with the data.
- I, the undersigned agree, whether signing as agent or as patient, to be individually obligated to pay the bill. Should the account be referred to an attorney for collection, I shall pay reasonable attorney's fees.
- I hereby assign payment directly to Vernon Physical Therapy, P.C., basic and/or major medical benefits herein specified and otherwise payable to me but not to exceed the regular charges for this period of treatment. I understand I am financially responsible for any charges not covered by this assignment.
- I understand that upon discharge I may request, in writing, a copy of my records.

SIGNED:_____ DATE: _____

7373 S. Alton Way, Suite 120 ►Centennial, Colorado 80112
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INSURANCE & BILLING INFORMATION

Please have insurance card and/or appropriate proof of coverage available

Primary Insurance:_____ Phone:_____

ID# _____ Group #:_____

Patient Relation to Insured: SELF SPOUSE CHILD OTHER_____

Secondary Insurance: _____ Phone: _____

Adjuster:_____ Claim #:_____

Is your case in litigation? Y N
Attorney's Name: _____ Phone: _____

PLEASE READ AND SIGN BELOW

Insurance and Billing Policy
I authorize Vernon Physical Therapy to bill my insurance company directly for the covered portion of charges, and I authorize payment of medical benefits directly to Vernon Physical Therapy, I authorize Vernon Physical Therapy, to release medical or other information necessary to process this claim. I understand that I am ultimately responsible for my physical therapy charges, and I agree to pay my deductible, my co-insurance or co-payment, and any charges not reimbursed by my insurance carrier. I understand that some insurance companies require medical or administrative pre-authorization for treatment, or have reimbursement limits on physical therapy treatment.
I understand I am ultimately responsible for knowing and meeting the requirements of my insurance plan.

Missed Appointment Policy
I agree to pay $45.00 per missed appointment, or appointment cancelled within 12 hours of scheduled time, that is not rescheduled within that same week. I understand that insurance WILL NOT cover this fee and I am ultimately responsible for these charges.

HIPAA
I acknowledge the receipt of Vernon Physical Therapy's HIPAA Notice of Privacy Practices.

Signature: _____ Date:_____

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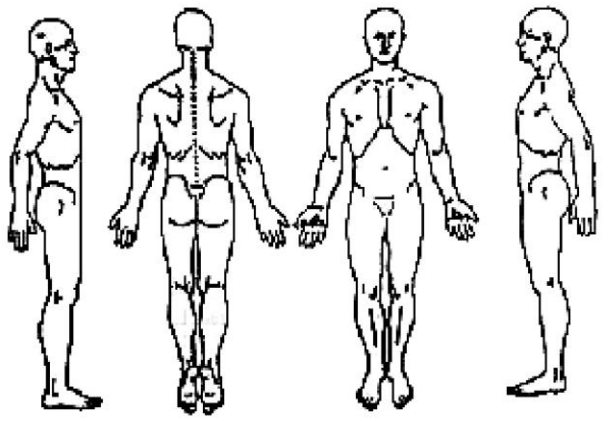
MEDICAL HISTORY

The purpose of this questionnaire is to help us understand your health status. Please complete this form and your therapist will answer any questions during your exam. This form is considered part of your medical record.

Please circle the area(s) where you have pain



Date symptoms began____/____/____

Rate your pain on a scale of 0-10

	← less pain										more pain →
BEST	0	1	2	3	4	5	6	7	8	9	10
WORST	0	1	2	3	4	5	6	7	8	9	10
NOW	0	1	2	3	4	5	6	7	8	9	10

Describe your pain *Please check all that apply*

- ☐ Constant
- ☐ Intermittent
- ☐ Sharp
- ☐ Dull
- ☐ Aching
- ☐ Stabbing
- ☐ Numbness
- ☐ Pins/Needles

What causes your pain to get worse?_____

What helps to reduce or control your pain?_____

Have you received any of the following in the last 12 months? *Please check all that apply*

- ☐ General Practitioner
- ☐ Physical Therapy
- ☐ Dry Needling
- ☐ Massage Therapy
- ☐ Neurologist
- ☐ Psychologist/Psychiatrist
- ☐ Chiropractic
- ☐ Podiatrist
- ☐ CT Scan
- ☐ EMG
- ☐ MRI
- ☐ X-Rays
- ☐ Emergency Dept

Other:_____

Do you have, or have you had, any of the following? *Please check all that apply*

- ☐ Neck Injury/Surgery
- ☐ Shoulder Injury/Surgery
- ☐ Elbow/Hand Injury/Surgery
- ☐ Back Injury/Surgery
- ☐ Knee Injury/Surgery
- ☐ Leg/Ankle/Foot Injury/Surgery
- ☐ Joint Replacement
- ☐ Arthritis/Swollen Joints
- ☐ Osteoporosis
- ☐ Severe or Frequent Headaches
- ☐ Numbness or Tingling
- ☐ Dizziness or Fainting
- ☐ Incontinence
- ☐ Bowel or Bladder Problems
- ☐ Weakness
- ☐ Asthma, Bronchitis, Emphysema
- ☐ Shortness of Breath/Chest Pain
- ☐ Coronary Heart Disease
- ☐ Pacemaker
- ☐ High Blood Pressure
- ☐ Heart Attack/Heart Surgery
- ☐ Blood Clot/Emboli
- ☐ Allergies
- ☐ Fever in the last 3 months
- ☐ Diabetes
- ☐ Infectious Diseases
- ☐ Cancer/Chemotherapy/Radiation
- ☐ Difficulty Sleeping
- ☐ Latex Sensitivity/Allergy
- ☐ Weight Loss/Gain: _____lbs.
- ☐ Hernia
- ☐ Thyroid Trouble/Goiter
- ☐ Blurred or double vision
- ☐ Chemical dependency
- ☐ Depression

Other:_____

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MEDICAL HISTORY

Please list any significant injuries/surgeries you have had and the approximate dates

_____

_____

_____

_____

_____

During the past week, have you taken any of the following medications?

YES NO Advil/Motrin/Aleve/Ibuprofen
YES NO Tylenol/Acetaminophen
YES NO Decongestant/Antihistamines
YES NO Supplements/Vitamins/Herbal remedies
YES NO Aspirin
YES NO Antacids
YES NO Laxatives

Please list any other medications you are currently taking *include dosage and frequency*

_____

_____

_____

_____

Have you fallen in the last year? Yes ____ No ____

If yes, how many times? _____Please list any injuries:_____

Social Habits

How many days per week do you get at least 30 minutes of exercise?_____
Do you drink alcohol?_____ How many drinks per week?_____
Do you smoke or use tobacco? _____ How many packs per day?_____
How often do you consume caffeine products?_____
Please list any leisure or recreational interests: _____
_____
List any activities you have avoided or altered because of pain:_____

Please list any other information that you feel should be known or concerns you may have

_____

_____

_____

_____

_____

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