PINAMONTI physical therapy

PATIENT REGISTRATION FORM

Today's Date:	

PATIENT INFORMATION

Patient's Last Name: First: Middle:

Address: City: State: Zip:

Home Phone: Cell: Email:

Date of Birth: Sex: Marital Status: Social Security Number:

Employer: Work Phone Number:

Spouse's Name: Spouse's Contact Number:

Emergency Contact: Phone Number: Relationship:

Guarantor Name: Address: Phone Number: Relationship:

INSURANCE INFORMATION

Primary Insurance: Policy Number:

Secondary Insurance: Policy Number:

Insured's Name (if not self): Insured's Date of Birth:

Auto accident / Claim number:

Referring Doctor (if referred): Primary Care Doctor:

Date of Onset of Illness / Injury / Accident

Physical Therapy is for treatment of:
post-op back/neck work injury other: _____

How did you hear about Pinamonti Physical Therapy? (Circle one - if "Other" please specify)

Doctor Friend/Relative Prior Patient Radio Print TV Internet Phone Book Employer Other _____

Please indicate method of payment (deductible, co-pay, non-covered services):

☐ Cash ☐ Check

☐ Mastercard
☐ Visa
☐ Discover
☐ American Express

Account # _____ Exp: _____

_____ _____

Signature Date:

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MEDICAL HISTORY QUESTIONNAIRE

Height _____

Weight _____

BMI _____

GENERAL HEALTH:

Allergies: _____

Cancers: _____

Cardiac / Heart / Stroke: _____

Diabetes: _____

Eyes / Vision: _____

Gastrointestinal: _____

Hearing: _____

Neurological: _____

Renal Failure / Dialysis: _____

Respiratory: _____

Skin: _____

Other: _____

Are you currently being treated by a physician for any medical condition? _____

MEDICAL EQUIPMENT USED?

Cane / Walker / Crutches: _____

Wheel Chair / Scooter: _____

Oxygen: _____

Hospital Bed: _____

Lift: _____

Handicap Equipped Van: _____

Other: _____

MEDICATIONS and DOSAGE:

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature Date:

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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Billing Policy, Release, and Authorization

I authorize Pinamonti Physical Therapy, PA, to bill my insurance company directly for the covered portion of charges, and I authorize payment of medical benefits directly to Pinamonti Physical Therapy. I authorize Pinamonti Physical Therapy to release medical or other necessary information to process this claim. ***I understand that I am ultimately responsible for my physical therapy charges, and I agree to pay my deductible, co-insurance or co-payment, and any charges not reimbursed by my insurance carrier. I also understand that any payment I make with a credit card or debit card is subject to a convenience fee of 3.5%***

A 15% filing fee will be applied to the entire outstanding balance if the account is declared delinquent and is forwarded to collections.

I understand that some insurance companies require medical or administrative pre-authorization for treatment, or have reimbursement limits on physical therapy treatment. I understand that I am responsible for knowing and meeting the requirement of my insurance plan.

Any diagnosis provided by your Physical Therapist is not considered a medical diagnosis. A medical diagnosis may only be provided by a physician.

I will notify Pinamonti Physical Therapy of any cancellation I may have to make. ***In an instance of cancellation without 24 hours notice or no-show to a scheduled appointment, we reserve the right to charge you a $20 fee.***

Signature _____ Date: _____

Consent for Treatment

Your Physical Therapist will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I, the undersigned, do hereby agree and give my consent for Pinamonti Physical Therapy, PA to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

_____ _____

Signature Date:

Our **PRIVACY NOTICE** describes how medical information about you may be used and disclosed and how you can get access to this information. Please review our posted copy carefully. A copy of our **PRIVACY NOTICE** will also be posted in your chart.

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Medicare Secondary Payer Questionnaire

Patient Name _____ Signature: _____

Date of Initial Treatment _____

1. Are you a Veteran? ☐ Yes ☐ No
   - Did the VA refer you here for treatment? ☐ Yes ☐ No
   - Do you have a VA fee basis ID card? ☐ Yes ☐ No

2. Do you have a Federal Black Lung Card? ☐ Yes ☐ No

3. Is this medical condition due to an accident? ☐ Yes ☐ No

   If yes, was it... Work related ☐
   - Auto ☐
   - Injured in own home ☐
   - Other ☐ _____

4. Are you covered by an employer's health insurance plan that would be primary to Medicare? ☐ Yes ☐ No

5. Have you been seen for outpatient physical therapy this calendar year? ☐ Yes ☐ No

   If yes, for what condition? _____

6. Have you been hospitalized in the last year? ☐ Yes ☐ No

   If yes, what was your discharge date? _____

7. Have you been seen by Home Health for any reason? ☐ Yes ☐ No

   If yes, what dates? _____

8. Living Situation:

   Home ☐ Do you have assistance if needed? ☐ Yes ☐ No

   Assisted Living Facility ☐

   Other: _____

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Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your protected health information (i.e., individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- To other health care providers (i.e., your physician, orthopedic surgeon etc.) in connection with our rendering physical therapy treatment to you (i.e., to determine the appropriate plan of care, treatment etc.);

- To third party payors or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);

- To certifying, licensing and accrediting bodies (i.e., the Kansas State Board of Healing Arts, etc.) in connection with obtaining certification, licensure or accreditation;

- Internally, to all staff members who have any role in your treatment;

- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;

- To your family and close friends involved in your treatment; and/or,

- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

- We may mail appointment reminders in postcard form, leave messages about appointments on answering machines, which may be read or overheard by others.

- We may use or disclose your health information when we are required to do so by law.

- We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

-continued-

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.
Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information; and,
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- To abide by the terms of our Privacy Notice that is currently in effect;
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

PATIENT ACKNOWLEDGMENT

You may refuse to Sign This Acknowledgement

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

_____ _____
Patient or Guardian: Date:

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

__ Individual refused to sign
__ Communications barriers prohibited obtaining the acknowledgement
__ An emergency situation prevented us from obtaining acknowledgement
__ Other _____