PATIENT REGISTRATION

NAME: (Last) _____(First) _____(MI)_____

Home Address_____

City_____State _____ ZIP_____ email _____

Cell phone _____ Home phone _____

Social Security # _____

Birth Date _____ Sex _____

Insurance Guarantor _____ SS# of Guarantor _____

Guarantor's Birthdate _____

Primary Insurance _____

Plan # _____ Group #_____

Second Insurance _____

Referring Physicians Name _____

address _____

Phone _____ Fax _____

Diagnosis and /or reason for referral _____

Emergency Contact # _____ relation _____

How did you hear about Bercutt Physical Therapy & Wellness Center? Circle One

Doctor Social Media Website Friend or relative other _____

Signature _____ Date _____

WE NEED TO MAKE A COPY OF YOUR INSURANCE CARD

Patient Authorization Record

Initial here	
	Authorization for Treatment ➢ I hereby give authorization for the performance of such rehabilitation procedures as permitted by ***Bercutt Physical Therapy & Wellness Center*** Statutes under the appropriate scope of practice are, in the judgment of my Therapist, deemed necessary.
	Authorization for Release of Information ➢ I agree that ***Bercutt Physical Therapy & Wellness Center*** may provide information from my medical record to persons involved in my medical care. ➢ I authorize the release of medical information necessary to obtain payment of any benefits available to me to ***Bercutt Physical Therapy & Wellness Center*** for services rendered. ➢ I agree that ***Bercutt Physical Therapy & Wellness Center*** may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment. ➢ I have read "Notice of Privacy Practices" mandated by HIPAA.
	Authorization for Release of Payment ➢ I authorize that direct payment of any benefits available to me be released to ***Bercutt Physical Therapy & Wellness Center*** for services rendered.
	Patient Agreement ➢ I agree to pay ***Bercutt Physical Therapy & Wellness Center*** charges for services rendered to me during my course of treatment. ➢ I agree to pay those charges which may not be paid by my health insurance and are my responsibility per my insurance benefit. If I do not pay for charges that are my responsibility, I agree to pay ***Bercutt Physical Therapy & Wellness Center*** collections costs including attorney and court fees.
	Medicare, Medicaid, and Similar Benefits ➢ I agree that the information given to ***Bercutt Physical Therapy & Wellness Center*** in applying for benefits under Medicare, Medicaid, and Maternal or Child Health services are complete and accurate. I agree that *(insert Company name here)* may give Social Security Administration or its fiscal intermediary's information necessary to process claims.
	Workers Compensation ➢ I agree that the information given to ***Bercutt Physical Therapy & Wellness Center*** in applying for benefits under Workers Compensation is complete and accurate. I agree that ***Bercutt Physical Therapy & Wellness Center*** may give intermediary's information necessary to process claims.

Patient signature Date

Printed patient name Witness Signature Date

Signature of Legal Representative/POA

PATIENT HISTORY

Name: _____ **Age:** _____ **Date:** _____

1. Describe the current problem that brought you here? _____
_____

2. When did your problem first begin? __Months ago or _____years ago

3. Was your first episode of the problem related to a specific incident? Yes / No

4. Since the time is it:
staying the _____same _____getting worse _____getting better _____
Why or how? _____

5. If pain is present, rate pain on a 0-10 scale, 10 being the worst. _____ Describe the nature of the pain (i.e. constant burning, intermittent ache) _____
_____

6. What makes pain/problem better?_____
Worse?_____

7. Activities/events that cause or aggravate your symptoms. Check/circle all that apply

_____Sitting greater than _____minutes
_____Walking greater than _____minutes
_____Standing greater than ____minutes
_____Changing positions (i.e. sit to stand)
_____Light activity (light housework)
_____Vigorous activity/exercise
_____Sexual activity
_____Other, please list _____
_____

_____With cough/sneeze/straining
_____With laughing/yelling
_____With lifting/bending
_____With cold weather
_____With triggers: water/key in door
_____With nervousness/anxiety
_____No activity affects the problem

8. What relieves your symptoms? _____
_____

9. How has your lifestyle/quality of life been altered/changed because of this problem?
Social activities (exclude physical activities), specify_____
Diet/Fluid intake, specify_____
Physical Activity, specify_____
Work, specify_____
Other_____

10. Rate the severity of this problem from 0 to 10, 0 being no problem, 10 being the worst. _____
11. What are your treatment goals? _____
_____

Since the onset of your current symptoms have you had:

Y/N	Fever/chills	Y/N	Malaise(unexplained tiredness)
Y/N	Unexplained weight change	Y/N	Unexplained muscle weakness
Y/N	Dizziness or fainting	Y/N	Night pain/sweats
Y/N	Change in bowel/bladder function	Y/N	Numbness/tingling

Y/N Other/describe_____

_____

Health History: Date of last physical exam? _____Tests performed _____

_____

General Health: Excellent Good Average Fair Poor
Occupation _____Hours/week _____On disability/leave?_____
Activity restrictions? _____
Mental Health: Current level of stress High___Med__Low__
Current psych therapy? Y/N
Activity/exercise: None 1-2 days/week 3-4 days/week 5+ days/week
Describe: _____

Do you have a history of falls? Y/N When?_____

Have you ever had any of the following conditions or diagnoses? Circle all that apply/describe

Cancer	Stroke	Emphysema/chronic bronchitis
Heart Problems	Epilepsy/seizures	Asthma
High Blood Pressure	Multiple Sclerosis	Allergies (list below)
Ankle swelling	Head injury	Latex sensitivity
Anemia	Osteoporosis	Hypothyroid/Hyperthyroid
Low back pain	Chronic Fatigue Syndrome	Headaches
Sacroiliac/tailbone pain	Fibromyalgia	Diabetes
Alcoholism/Drug problem	Arthritic conditions	Kidney Disease
Childhood bladder problem	Stress Fracture	Irritable Bowel Syndrome
Depression	Joint replacement	Sexually transmitted disease
Smoking history	Bone fracture	Physical or sexual abuse
Anorexia/bulimia	Rheumatoid Arthritis	Hepatitis HIV/AIDS
Vision/eye problems	Sports injuries	Raynaud's (cold hands and feet)
Hearing loss problems	TMJ/neck pain	Pelvic pain

Other/Describe _____

Surgical/Procedure History

Y/N	Surgery for your back/spine	Y/N	Surgery for your bladder/prostate
Y/N	Surgery for your brain	Y/N	Surgery for your bones/joints
Y/N	Surgery for female organs	Y/N	Surgery for your abdominal organs

Other/describe_____

Ob/Gyn History *(females only)*

Y/N Childbirth vaginal deliveries #_____ Y/N Vaginal dryness
Y/N Episiotomy #_____ Y/N Painful periods
Y/N C-section #__ Y/N Menopause- when?_____
Y/N Difficult childbirth #_____ Y/N Painful vaginal penetration
Y/N Prolapse or organ falling out Y/N Pelvic pain
Y/N Other/describe_____

Uro History *(Males Only)*

Y/N Prostate disorders Y/N Erectile dysfunction
Y/N Shy bladder Y/N Painful ejaculation
Y/N Pelvic pain
Y/N Other/describe _____

Medications- pills, injection, patch Start Date Reason for taking

_____
_____
_____
_____
_____

Over the counter- vitamins, etc. Start Date Reason for taking

_____
_____
_____
_____

Do you feel safe at home? Y/N

Previous Physical Therapy? (when/where)_____

Are you currently in Home Health? Y/N

Signature _____ Date _____

Payment Policy

Patient payments are due before services are rendered.
Bercutt Physical Therapy & Wellness Center does our best to inform patients of their payment responsibilities beforehand but it is ultimately the patients responsibility to know their health insurance benefits.
If you have any questions about co-pays, co-insurance, deductibles, facility fees and covered and non-covered services, please see the front desk attendant and we will do our best to help.

I, _____ have read the above stated policy and agree to be responsible for my health and for any fee associated with my inability to adhere to this policy.

_____
Print Patient Name

_____ _____
Patient Signature/Legal Representative Date

Cancellation and No Show Policy

You are coming to Therapy to remedy the condition that is affecting you; therefore it is absolutely necessary that you attend all of your scheduled appointments.

ALL missed appointments MUST be made up the same week, so you may fully recover.

Bercutt Physical Therapy & Wellness Center requires 24 hour advance notice for any cancellation. If you are unable to give 24 hour advance notice or you do not show for your scheduled appointment an administrative fee of $50 will be applied to your uncovered services and payment of fee will be expected.

I, _____ have read the above stated policy and agree to be responsible for my health and for any fee associated with my inability to adhere to this policy.

_____
Print Patient Name

_____ _____
Patient Signature/Legal Representative Date