Patient Express Registration

Name _____ Date _____
Last **First** **MI**

Mailing Address _____
Street **City** **State** **Zip Code**

Physical Address _____
Street **City** **State** **Zip Code**

Home Phone **w/area code** _____ Work Phone _____ Cell Phone _____

Contact Preference: ☐ Home ☐ Work ☐ Cell E-mail Address _____

Social Security Number _____ Birth date _____ Age _____ Sex: ☐ Female ☐ Male

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner; Registered in: ____ Spouse/Partner's Name _____ ☐ Divorced ☐ Widowed

Employer _____ Employer's Address _____

Primary Care Physician _____ Referring Physician _____

Emergency Contact _____ Relationship _____

Home Phone **w/area code** _____ Work Phone _____ Cell Phone _____

INSURANCE INFORMATION – PLEASE GIVE YOUR CARDS TO THE FRONT DESK FOR SCANNING

Primary Insurance _____

Insured's Name _____ Birth date _____

ID Number _____ Group Number _____

Secondary Insurance _____

Insured's Name _____ Birth date _____

ID Number _____ Group Number _____

IF YOU HAD AN ACCIDENT PLEASE COMPLETE THIS SECTION

Date of accident _____ How did it happen? ☐ Auto ☐ Work ☐ Other State in which injury occurred _____

Claim Number _____ Insurance Company (worker's comp or your auto PIP) _____

Address _____ Claims Adjuster _____ Phone number _____

Please tell us how you learned of our service or whom we can thank

☐ I was a **Former Patient** ☐ **Former Patient** recommendation ☐ **Health Club/Professional** recommendation

☐ **Family/Friend/Co-Worker** recommendation ☐ **Doctor** Recommendation ☐ **Radio** advertisement

☐ **Yellow Page** advertisement ☐ Found you on the **Internet** Website: _____

☐ **TV/Billboard** advertisement ☐ **Publication/Newspaper** advertisement Publication: _____

☐ **Clinic Sign** ☐ Saw you at an **Event** Event: _____

I learned about you **another way.** Please explain _____

Progressive

PATIENT QUESTIONNAIRE / HEALTH HISTORY

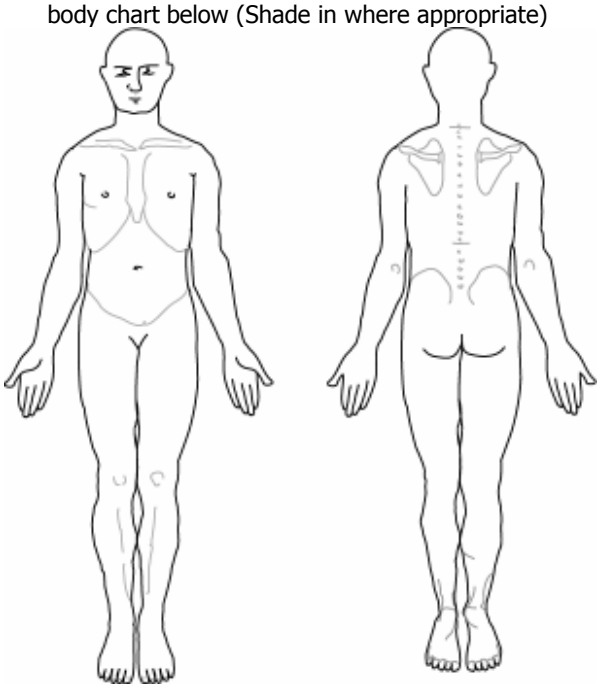
NAME: **DATE:** _____

To insure you receive a complete and thorough evaluation. Please provide us with important background information on the following form. If you do not understand the question, your therapist will assist you. Thank you.

HISTORY OF PRESENT CONDITION

1. What are your symptoms? _____
_____
_____

Localize areas of **pain** or **abnormal** sensation on the body chart below (Shade in where appropriate)



2. When did your symptoms begin?
(Please indicate a specific date if possible)_____

3. Was the **onset** of this episode gradual or sudden?(Check one)
❒ (1) gradual ❒ (2) sudden

4. Which of the following **best describes** how your injury occurred? (if your condition is post-surgical please indicate as per original injury)
❒ (1) lifting
❒ (2) a MVA (car accident
❒ (3) a fall
❒ (4) overuse (cumulative trauma)
❒ (5) trauma
❒ (6) degenerative process
❒ (7) during recreation/sports
❒ (8) running
❒ (9) a blow to the face
❒ (10) being hit by a ball
❒ (11) a dental appointment
❒ (12) throwing
❒ (13) an incident at work
❒ (14) unknown
❒ (15) other _____

5. Since onset, are your symptoms getting: (Check one)
❒ (1) better ❒ (2) worse ❒ (3) not changing

6. Have you had similar symptoms in the past? (1)❒ Yes (2) ❒ No

More than one episode? (1) ❒ Yes (2) ❒ No

7. Nature of pain/symptoms (check all that apply)
❒ (1) sharp ❒ (4) aching ❒ (7) constant
❒ (2) dull ❒ (5) periodic ❒ (8) other _____
❒ (3) throbbing ❒ (6) occasional _____

8. As the day progresses, do your symptoms: (Check one)
❒ (1) increase ❒ (2) decrease ❒ (3) stay the same

9. Does the pain wake you at night? ❒ (1) No ❒ (2) Yes
if "yes", is it present ❒ (1) while lying still
❒ (2) only when changing positions
❒ (3) both

10. Do you have pain/stiffness upon getting out of bed in the morning? ❒ (1) Yes ❒ (2) No

11. In what position do you sleep? (Check all that apply)
❒ (1) right side ❒ (4) back ❒ (6) back, sides, stomach
❒ (2) left side ❒ (5) chair/recliner ❒ (7) other _____
❒ (3) stomach

12. Since the onset of your current symptoms have you had:
❒ (1) any difficulty with control of bowel or bladder function
❒ (2) fever/Chills
❒ (3) any numbness in the genital or anal area
❒ (4) numbness
❒ (5) any dizziness or fainting attacks
❒ (6) weakness
❒ (7) unexplained weight change
❒ (8) night pain/sweats
❒ (9) malaise (vague feeling of bodily discomfort)
❒ (10) problems with vision/hearing
❒ (11) none of the above

13. What aggravates your symptoms? (Check all that apply)
❒ (1) sitting
❒ (2) going to/rising from sitting
❒ (3) lying down
❒ (4) walking
❒ (5) up/down stairs
❒ (6) reaching overhead
❒ (6) reaching in front of body
❒ (6) reaching behind back
❒ (6) reaching across body
❒ (7) talking, chewing, yawning, all (circle one)
❒ (8) recreation/sports including _____
❒ (9) repetitive activities including _____
❒ (10) household activities including _____
❒ (11) standing
❒ (12) squatting
❒ (13) sleeping
❒ (14) coughing/sneezing
❒ (15) taking a deep breath
❒ (16) looking up overhead
❒ (17) swallowing
(18) stress
❒ (19) sustained bending
❒ (20) other _____

14. What relieves your symptoms? (Check all that apply)
❒ (1) sitting
❒ (2) heat
❒ (3) cold
❒ (4) stretching
❒ (5) wearing a splint/Orthotic
❒ (6) rest
❒ (7) standing
❒ (8) walking
❒ (9) exercise
❒ (10) lying down
❒ (11) massage
❒ (12) medication
❒ (13) nothing
❒ (14) other_____ _____

15. Have you had any previous treatment for this condition? (Check all that apply)

- ❒ (1) none
- ❒ (2) medication (oral)
- ❒ (3) joint manipulation
- ❒ (4) exercise
- ❒ (5) massage therapy
- ❒ (6) traction
- ❒ (7) bracing/taping
- ❒ (8) injection into the spine
- ❒ (9) injection into the skin/muscles
- ❒ (10) physical therapy
- ❒ (11) hypnosis
- ❒ (12) biofeedback
- ❒ (13) TENS unit
- ❒ (14) acupuncture
- ❒ (15) bed rest
- ❒ (16) overnight hospitalization
- ❒ (17) casting
- ❒ (18) other_____

16. Have you had any of the following tests?

- ❒ (1) none
- ❒ (2) x-rays
- ❒ (3) CT Scan
- ❒ (4) MRI
- ❒ (5) Arthrogram
- ❒ (6) Stress X-ray Test (Telos)
- ❒ (7) Bone Scan
- ❒ (8) NCS
- ❒ (9) Fluoroscope
- ❒ (10) Vestibular
- ❒ (11) other_____

Test Results:_____

MEDICATION

Please list any prescription medications you are currently taking (pain pills, injections and/or skin patches, etc.):

_____

_____

Prescribing MD:_____ Phone:_____

Are you currently taking any of the following over the counter medications?

- ❒ (1) aspirin
- ❒ (2) Tylenol
- ❒ (3) corticosteroids
- ❒ (4) antihistamines
- ❒ (5) vitamins/mineral supplements
- ❒ (6) Advil/Motrin/ Ibuprofen
- ❒ (7) other_____

PREVIOUS FUNCTIONAL LEVEL

❒ **Independent in all activities** (work, community, home, recreation)

Self-care

- ❒ Independent in all self-care activities (bathing, toileting, dressing, etc.)
- ❒ Difficulty performing self-care activities
- ❒ Need assistance with self-care activities
- ❒ Difficulty performing household chores

Social

- ❒ Need assistance with activities in community outside of home

Hobbies:_____

WORK HISTORY

Occupation_____

- ❒ (1) employed full time
- ❒ (2) employed part time
- ❒ (3) self employed
- ❒ (4) homemaker
- ❒ (5) student
- ❒ (6) retired
- ❒ (7) unemployed
- ❒ (8) other_____

Physical activities at work (check all that apply)

- ❒ (1) sitting
- ❒ (2) standing
- ❒ (3) phone use
- ❒ (4) repetitive lifting
- ❒ (5) heavy lifting
- ❒ (6) computer use
- ❒ (7) heavy equipment operation
- ❒ (8) driving
- ❒ (9) other_____

Are you currently receiving or seeking disability for this condition? ❒ (1) Yes ❒ (2) No

If not performing your normal activities at work do you plan to RETURN to your previous activity level?

❒ (1) Yes ❒ (2) No

LIVING SITUATION

- ❒ (1) live alone
- ❒ (2) live with family members/others
- ❒ (3) live with caregiver
- ❒ (4) home/apartment
- ❒ (5) retirement complex (SNF/ICF)
- ❒ (6) assisted living complex
- ❒ (7) other_____

Setting

- ❒ (1) stairs (railing)
- ❒ (2) stairs (no railing)
- ❒ (3) no stairs
- ❒ (4) ramp
- ❒ (5) elevator
- ❒ (6) uneven ground
- ❒ (7) other_____

GENERAL HEALTH

How would you rate your general health?

❒ Excellent ❒ Average ❒ Poor
❒ Good ❒ Fair

Do you exercise outside of normal daily activities?

❒ 5+ days/wk ❒ 1-2 days/wk ❒ zero
❒ 3-4 days/wk ❒ occasionally

Exercise, Sports/Recreation consisting of _____

_____

Do you drink caffeinated beverages?

❒ No ❒ Yes How many/much per day_____

Do you smoke?

❒ No ❒ Yes Packs of cigarettes per day_____

What is your stress level?

❒ Low ❒ Medium ❒ High

Are you seeing any health care providers other than the physical therapist for this current condition? (Please list)_____

_____

_____

PAST MEDICAL HISTORY

Have you ever had/been diagnosed with any of the following conditions? (Check all that apply)

- ❒ Cancer (type)_____
- ❒ Depression
- ❒ Stroke
- ❒ Kidney problems
- ❒ Thyroid problems
- ❒ Diabetes
- ❒ Multiple sclerosis
- ❒ Arthritis
- ❒ injury
- ❒ Stomach problems
- ❒ Parkinson's disease
- ❒ Infectious diseases (i.e. hepatitis, tuberculosis, etc.)
- ❒ Heart problems
- ❒ High blood pressure
- ❒ Lung problems
- ❒ Blood disorders
- ❒ Epilepsy/seizures
- ❒ Allergies
- ❒ Rheumatoid arthritis
- ❒ Osteoporosis Head
- ❒ Broken bone
- ❒ Circulation/vascular problems
- ❒ Other_____

Please list any recent/relevant past surgeries related to your current problem:

SURGERY **DATE**

_____

_____

_____

FAMILY HISTORY

Has anyone in your immediate family (parents, brothers, sisters) ever been treated of any of the following?

- ❒ Diabetes
- ❒ Heart disease
- ❒ High blood pressure
- ❒ Stroke
- ❒ Other_____
- ❒ Cancer
- ❒ Arthritis
- ❒ Osteoporosis
- ❒ Psychological condition

Office Policies

We are dedicated to providing highly individualized care for patients with orthopedic injuries. Insurance companies will not dictate the care you receive at Progressive Therapeutics Your plan of care is achieved through the professional assessment of your therapist and physician, and based on your specific functional goals. Please read the following policies and sign below.

_____1. **Insurance**: In order to maintain our high standard of care, Progressive Therapeutics is contracted with many insurance companies. As a courtesy to you, the insured, Progressive Therapeutics verifies insurance benefits and coverage at the time you begin our professional services. This verification is only an estimation of insurance benefits at the time of verification and in no way a promise on behalf of the insurance company to pay for and services rendered. It is your responsibility to make sure we have the most current information on your insurance so we may bill it on your behalf. You as the patient, or legal guardian, are responsible for all charges that the carrier does not pay on the claim including any denials, deductibles, co-payments and co-insurance due. You are also responsible for knowing the benefits provided by your insurance coverage including coverage, exclusions and limitations. In the event your insurance company forwards payment directly to you, instead of to Progressive Therapeutics, you are required to immediately deliver such payment to Progressive Therapeutics. You also understand and agree that if it becomes necessary to commence legal action for the collection of any outstanding charges on your account, you will be responsible for any costs and court costs, in addition to the outstanding balance.

As verified on _____, we expect your insurance company to cover _____% of the amount they consider reasonable and customary charges. Your portion should be the remaining _____% plus any additional amount not paid by your insurance company. Additionally, there is/is not a co-payment of $__ due at each visit. Please also note that deductibles must be met prior to insurance payments made on your behalf. Progressive Therapeutics *is not responsible for verifying deductible or co- payment amounts.*

x_____**2. Authorization to furnish information**: I hereby authorize Progressive Therapeutics to release all medical records concerning my health care to my physician(s), insurance representative(s), insurance carrier(s) and/or legal representative(s). Medical information and records may be released by facsimile, telephone, and mail. I also authorize my insurance carrier(s) to pay Progressive Therapeutics directly for any services rendered.

x_____**3. Automobile Accidents**: You are responsible for your bill at the time of service. If we can verify that liability has been accepted by the insurance company, that "medical payments" are available under the insurance coverage, and that bills are paid upon receipt (not at time of settlement), we will, as a courtesy to you, bill your insurance company if your credit card is on file with us. We do not wait for settlement from attorneys or wait for settlement from any automobile carriers. If payment for services rendered is not received within 30 days of billing, full payment will be due immediately and charged to your credit card.

x_____**4. Workers' Compensation**: Authorization for treatment from your employer's insurance carrier or employer if self- insured, must be received by Progressive Therapeutics prior to onset of therapy. When the patient's initial authorization has expired or when the authorized physical therapy visits are used, Progressive Therapeutics must have re-authorization from the insurance carrier or employer (if self-insured) for physical therapy to continue.

x_____**5. Medicare**: Our office accepts Medicare assignment. Medicare payments will come directly to us. The patient will be responsible for charges not paid or covered by Medicare which include but is not necessarily limited to the annual deductable, 20% of Medicare approved charges, which is the patient's co-insurance, costs past the annual $1,840.00 CAP and any service not covered by Medicare. We will inform you prior to reaching your CAP or any uncovered service that we are aware of.

x_____**6. Durable Medical Equipment (DME) and Supplies**: DME and supplies are not reimbursable by insurance companies, and must be paid for at the time of your therapy session.

x_____**7. Payment**: Payments, co-payments and/or co-insurance are expected when services are rendered (each visit). If alternative arrangements are necessary, please contact us directly. We accept VISA, MasterCard, American Express, and Discover, debit cards, checks and cash. We expect co-insurance accounts to be paid in full within 30 days from the last day of treatment.

x_____**8. NON Pregnancy Verification:** I do hereby state that to the best of my knowledge I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period:_____ .

x **9. Late Charges/Returned Checks**: Any account that remains open beyond 30 days from last day of treatment will be subject to a $10.00 fee for each month that the amount is not paid in full. There will be a $35.00 fee for each returned check.

x **10. Canceled/Missed Appointments**: If a patient is more than 15 minutes late for an appointment, we reserve the right to reschedule. Late arrivals are subject to the full fee for the session. We require 24 hour notice for cancellations. Appointments that are canceled with less than 24 hours notice or no show appointments are subject to an $85 charge, which is not reimbursable by insurance companies. Also, if a patient late cancels or no-shows more than two times, the patient is responsible for the full charge of the visit and the rest of his / her scheduled visits will be removed.

x **11. Right to Triage**: Progressive Therapeutics will make every endeavor to see you at your convenience. However, Progressive Therapeutics reserves the right to triage clients on emergency cases. You may have to be treated by another therapist. This is our team approach to treatment.

x **12. Fees**: Our fees are subject to change without notice. Please see our fee schedule for all charges. After the initial evaluation, subsequent physical therapy sessions are billed in 15 minute increments and are typically one (1) hour. The therapist reserves the right to treat the patient for a 50-minute treatment session, leaving 10 minutes for necessary paperwork and documentation for the visit.

x **13. Consent for Treatment**: The patient hereby consents to the administration of appropriate evaluation and therapeutic procedures/modalities as requested by the physician prescribing care. Even though your doctor has referred you to therapy for a certain number of visits or length of time, the therapist will monitor your progress and adjust your treatment accordingly. I hereby give my consent to Progressive Therapeutics to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in my health chart record. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).I understands that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physical therapist. I also understand that I will not be able to revoke this consent in cases where the physical therapist has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physical therapist's office. I understand and am informed that, as in all health care, in the practice of Physical Therapy there is a small inherent risk of injury which includes but is not limited to, muscle strains, sprains, fractures, dislocation, intervertebral disc injury, and cardiovascular accident. I understand that my Physical Therapist will not be able to anticipate all potential complications, but will rely on clinical expertise and judgment to determine the correct course of treatment, which will be in my best interests considering all known facts. I understand that results are not guaranteed and that I have the opportunity to discuss the purposes and risks associated with all recommended evaluation and treatment procedures at any time.

x **14. Our Pledge Regarding Medical Information**: We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of care and services you receive at Progressive Therapeutics. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by Progressive Therapeutics. We are required by law to make sure that medical information that identifies you is kept private and give you notice of our legal duties and privacy practices with respect to medical information about you.

x **15. Treatment of Minor**: If a patient is under 18 years of age, and a parent is not able to attend sessions of physical therapy with the minor, the parent or guardian(s) signature for authorization allows Progressive Therapeutics to commence Physical therapy, occupational therapy and/or speech therapy treatments with the patient who is a minor. The parent or guardian is also accepting full financial responsibility for the treatment.

x **16. Right To Receive payment:** I authorize and assign to you, Progressive Therapeutics, the right to receive direct payment from my attorney or any insurance company for services rendered to myself/child/parent and I am financially responsible for non-covered services. I further authorize the endorsement of my name to any draft or check containing my name to which you are legally entitled. I also assign to you, the medical provider, and grant the right of lien against any and all claims against any third party insurance company up to the amount of the bill for treatment.

I have read the above policies and understand that payment is due when services are rendered. I agree to accept full financial responsibility for medical expenses incurred at Progressive Therapeutics.

Patient's Name: X_____

Patient's Signature: X_____ Date: _____

Parent's or Guardian's Signature: X_____

(If patient is less than 18 years)