MEDCARE THERAPY CENTER, LLC

Orthopedics ~ Sports Rehab ~ Balance Therapy ~ Massage Therapy

"Quality Care for Your Faster Recovery"

REGISTRATION SHEET

Patient Information: Date: _____

Patient's Name: _____
First **Middle Initial** **Last**

Address: _____
Street **City** **State** **Zip**

S.S. # of Patient: _____ Date of Birth: _____

Age of Patient: _____ Sex: Male/Female _____

Contact Number/Phone Number: _____ Marital Status: S - M - W - D **(circle one)**

Email Address:_____

Occupation: _____ Employer: _____

Name of Primary Care Physician:_____

Parent/Guardian Information (*if patient is under 18 years old*):

Name:_____ Soc. Sec. #_____

Birthdate:_____ Marital Status: Married_____ Single_____ Other_____ Employer:_____

Employer Telephone Number:_____

Emergency Information: In case of emergency, notify the following people:

1. Name:_____ Relationship:_____ Telephone:_____
2. Name:_____ Relationship:_____ Telephone:_____

How did you hear about us: __ Friend/Relative (name: _____)□ __Doctor □__Commercial □__Phonebook □__Billboard __ Internet __Sign on Building __ Program Ad □Other_____

Insurance Information: ***(please provide cards to registration desk to copy)***

***Primary Insurance* (billed first):**

Name of Insurance: _____

Policy Holder Name: _____

Policy Holder Date of Birth_____

Policy Holder Social Security #_____

Policy or Group #: _____

Identification #: _____

Relationship to Patient_____

***Secondary Insurance*:**

Name of Insurance: _____

Policy Holder Name: _____

Policy Holder Date of Birth_____

Policy Holder Social Security #_____

Policy or Group #: _____

Identification #: _____

Relationship to Patient: _____

Accident Information:

Accident/Present condition related to:

Work ☐ Yes ☐ No

Employer Name: _____

Employer Number: _____

Claims Adjuster/Case Worker Name: _____

Claims Adjuster/Case Worker Number: _____

Auto Accident ☐ Yes ☐ No

Due to another party: ☐Yes ☐No

Name of person liability: _____

Are you filing a claim related to the accident? ☐ Yes ☐ No

Name of Lawyer: _____

Name of Adjuster/Insurance Co.: _____

Claim #: _____

Personal Injury ☐ Yes ☐ No

No Accident ☐ Yes ☐ No

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HEALTH QUESTIONNAIRE

1. **Name:**_____ **Date of Birth:** _____

2. **Have you had physical, occupational or speech therapy this year**? ☐ Yes ☐ No If yes, please provide date and location
_____

3. **With whom do you live?**
_ Alone _ Spouse only _ Spouse and other(s) _ Child (not spouse)
_ Other relative(s) _ Group setting _ Personal Care Attendant _ Other: _____

4. **GENERAL HEALTH STATUS**
   a. Please rate your health: _ Excellent _ Good _ Fair _ Poor
   b. Have you had any major life changes during the past year? (e.g., new baby, job change, death of a family member) _ Yes _ No
   c. Are you pregnant? Yes___ No____ Unsure_____

5. **SOCIAL/HEALTH HABITS**

Do you currently smoke tobacco? _ Yes _ No If yes, how many packs of cigarettes/cigars per day _____

6. **MEDICAL/SURGICAL HISTORY** - *Please check if you have ever had:*

_ Arthritis _ Broken bones/fractures _ Osteoporosis
_ Circulation/vascular problems _ Heart problems _ Depression
_ High blood pressure _ Stroke _ Head injury
_ Diabetes/high blood sugar _ Low blood sugar/hypoglycemia _ Repeated infections
_ Multiple sclerosis _ Parkinson disease _ Cancer
_ Seizures/epilepsy _ Infectious disease _ Other: _____

Within the past year, have you had any of the following symptoms? *(Check all that apply)*

_ Chest pain _ Joint pain or swelling _ Bowel problems _ Other: _____
_ Hoarseness _ Shortness of breath _ Dizziness or blackouts
_ Coordination problems _ Weakness in arms or legs _ Urinary problems
_ Pain at night _ Weight loss/gain _ Nausea/vomiting

Have you ever had surgery? _ Yes _ No *If yes, please describe, and include date:*

Month _____ Year_____ _____
Month_____ Year _____ _____
Month _____ Year_____ _____

Do you have any electrical implanted devices? (i.e. pacemaker, bone stimulator, urinary control stimulator, etc…) Yes___ No___
Are you allergic to any medication or substances? Yes ___ No ___ If yes, please list: _____

7. **MEDICATIONS**

a. Do you take any prescription medications? _ Yes _ No
If yes, please list: _____

b. Do you take any non-prescription medications? _ Yes _ No
If yes, please list: _____

8. **OTHER CLINICAL TESTS- Within the past year, have you had any of the following tests?** *(Check all that apply)*

_ Arthroscopy _ Biopsy _ EKG (electrocardiogram) _ EMG (electromyogram)
_ Bone scan _ CT scan _ Echocardiogram _ MRI
_ X-rays _ Myelogram _ NCV (nerve conduction velocity) _ Stress test (e.g., treadmill, bicycle)
_ Other:_____

I hereby certify that I have personally answered all of the questions on this form and that my answers are true and complete to the best of my knowledge and belief.

Patient 's Signature: _____ Date: _____

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FINANCIAL POLICY

BILLING

As a courtesy to you, we will bill your primary and secondary health insurance companies. Please provide us with complete and accurate insurance information, as well as any change of address, telephone number of employer.

THIRD PARTY BILLING/RESONSIBILITY

Regardless of the cause of your injury, as the patient, you are responsible for your bill (this includes car accidents). Your insurance coverage is a contract between you and your insurance company. You are responsible for payment of your account. If your deductible has not been met, full payment of your office visit is required. If your deductible has been met, and your insurance covers a percentage of your therapy, you will be billed your part once insurance payment is received. If you have a set co-pay, it is due the day your treatment is rendered. If you have a question regarding insurance payments or the extent of services covered under your insurance plan, please contact your carrier regarding coverage.

PRIVATE PAY

If you do not have insurance, you will be considered private pay. You will be required to pay each visit in full at the time of treatment.

FINANCIAL DECISION

Which method of payment do you prefer in order to meet your financial responsibility?

Cash, Credit Card/Debit, or Check? _____***(You must select at least one.)***

(please ask our receptionist for ***a receipt of your payment****)*

CANCELLATIONS

A ***24-hour*** notice must be given when canceling an appointment, or charges may be added to your account.

FAMILY MEMBERS

If you choose to allow family members to enter the treatment area with you, you must keep them off any therapy exercise equipment. MedCare is not responsible for any injuries that would occur due to unauthorized use of equipment by yourself or any family member

CONSENT/ASSIGNMENT

I hereby consent to examination and treatment by MedCare Therapy Center, LLC and authorize the release of any and all information acquired in the course of my treatment or dealing in any manner with my treatment, including, but not limited to medical records, electronic media, oral communications to my insurance company, PCP or referring physician, employer or third party payer. I agree to hold MedCare Therapy, LLC Center harmless from the above information. I realize I have the right to refuse any procedure after having the risks and benefits explained to me. I authorize payment to be made directly to MedCare Therapy Center, LLC, including Medicare, Medicaid or other benefits payable from any source, for all services rendered. I understand I am ultimately responsible for payment of my account, and accept full responsibility for the cost of all services. I have read the above information and I fully understand that I am ultimately responsible for the fees.

Patient's Name: _____ Date: _____

(Please Print Name and Sign)

Guarantor's Name: _____

(***Print Name)***

Guarantor's Signature:_____ ***Date:***_____

Guarantor's Address:_____

Guarantor's Date of Birth:_____

BILL OF RIGHTS

ACCESS TO CARE

- Regardless of race, creed, national origin, or source of payment, you have the right to receive medical treatment and care.

RIGHT TO PRIVACY AND CONFIDENTIALITY

- You have the right to privacy regarding your medical care program including case discussion, consultation, examination and treatment.
- Your treatment and care shall be conducted discreetly and those not involved with your care must have permission to be present.
- All records pertaining to your care shall be treated as confidential and read only by the individuals directly involved in your care.
- You have the right to have a person of your own sex present during certain exams, procedures and treatments.

PERSONAL SAFETY

- You have the right to expect that reasonable safety standards be followed within the center practices and environment.

INFORMATION

- You have the right to know the identity and professional status of those providing you care.
- You have the right to be informed if your care is to be delivered under the auspices of any clinical training programs.
- You have the right to obtain complete and current information concerning your diagnosis, treatment and prognoses in terms you can readily understand. When it is not medically advisable to give this information to you, it should be made available to an appropriate individual on your behalf.
- You have the right to sufficient information to enable you to give informed consent prior to any procedure or treatment.
- You have the right to be informed by the practitioner responsible for your care of any continuing health care requirements following discharge.
- You have the right to be informed when a significant change in your medical status or psychological status has occurred altering treatment significantly.
- You have the right to voice grievances with respect to treatment of care. Patient/Family complaint forms are available and resolutions to grievances will be resolved promptly.

Patient's COPY

MEDCARE THERAPY CENTER'S COMPLIANCE POLICY

Compliance in attending PT is very critical to success in therapy. If you have to cancel or miss three physical therapy appointments during the course of your therapy, MedCare reserves the right to discontinue your treatments.

PATIENT SIGNATURE_____ DATE:_____