

Patient Registration Form – Commercial Insurance

Patient Name:	Preferred:
Address, City, State, Zip:	
DOB:	Social Security #:

Cell Phone:	Appointment Reminder Method
Home Phone:	<input type="checkbox"/> Text Message <input type="checkbox"/> Phone Call
Email:	<input type="checkbox"/> Email

Please keep in mind that communication via email over the Internet is not a secure form of communication. By providing your above contact information and signing below, you agree to receive information (such as appointment reminders, patient surveys, and other information relating to the physical therapy services provided to you) via the communication channels for which you provided the contact information.

Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Partner's Name:	
Financial Responsibility: <input type="checkbox"/> Self <input type="checkbox"/> Other, Please List Parent/Legal Guardian Name:		
Address and Phone Number, if Different from Above:		
Social Security #:	DOB:	Relation:
2nd Contact Info and Phone:		Relation:
General Physician:	Referred By:	

Have you had Physical Therapy treatment since January of this year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, # of Visits:
Have you had Chiropractic treatment since January of this year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, # of Visits:
Have you had Home Healthcare in the last 30 days? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, Home Healthcare Provider:

INSURANCE INFORMATION Please Note: A copy of your insurance card(s) will be kept on file. The patient is responsible to provide their most current insurance information.			
Primary Insurance:		Secondary Insurance:	
Group #:	Policy #:	Group #:	Policy #:
Insured Information:		Insured Information:	

Consent to Treat/Assignment of Benefits/Acknowledgements

I hereby authorize and consent to treatment/services for myself, or on the behalf of the above-named patient performed by the staff at Strive, Western Berks, and SOAR and/or as directed by my referring provider. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including risk or alternatives to the recommended treatment plan.

I assign payment for these services directly to Strive, Western Berks, and SOAR. I authorize the filing of claims to my insurance plan and authorize Strive, Western Berks, and SOAR to release necessary health information related to these services to process the claims. I certify that the information I have provided is accurate and complete.

In signing this form, I will promptly pay any required co-pay, coinsurance and/or deductible amounts. I accept that insurance plans may deny payments for what I believed were covered services, resulting in my responsibility for paying for these services.

I acknowledge that I have received the Notice of Privacy Practices, which describes the ways the practice may use or disclose my healthcare information. I understand that my healthcare information may be used for treatment, payment, healthcare operations and other permitted uses or disclosures as described in the Notice.

Signature of Patient/Guardian

Date

Print Name and Relationship to the Patient

Financial Policy

Name:

Cancellation/No Show

Successful therapy is dependent on a strong working relationship between the patient and the therapist. Maximum progress and success are made when the patient is an active participant in their home exercise program and attends all appointments.

Strive, Western Berks, and SOAR require a 24-hour notice for ALL cancellations. There may be a fee assessed which is not covered by insurance and would be an out-of-pocket expense for cancellations without proper notice.

If a cancellation is unavoidable, we do ask that you give us as much notice as possible so we may offer that appointment time to another patient.

- If you arrive later than 15 minutes after your scheduled appointment time, we may ask you to reschedule.
- After more than one cancellation or no show, we require that you call the day of for an appointment.
- 2 “no show” appointments may result in discharge from therapy.

Payment for services is due at the time services are rendered

We will verify your benefits with your insurance carrier. However, this does not guarantee that they will cover the prescribed treatment. By signing below, you are acknowledging that you are responsible for deductibles, copays, coinsurance, and non-covered services not paid by the insurance carrier and understand that you are fully responsible for any balance due for services rendered.

Patient/Guardian Signature:

Date:

Photo/Video Release

I grant to Strive, Western Berks, and SOAR and its affiliated entities, and its representatives and employees (collectively the “Company”) the right to take photographs and/or videos of me in connection with my participation in physical therapy services. I authorize the Company, to copyright, use and publish the same in print and/or electronically. I agree that the Company may use such photographs and/or videos of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and web content and waive any right to compensation, therefore I understand that I may revoke this authorization but only in writing delivered to the clinic Office Manager. I understand that if I choose to revoke this authorization, the revocation will not be effective for any uses and/or disclosures of my protected health information that have already been made in reliance on this authorization.

(Please check a box below)

Agree Decline

Patient/Guardian Signature:

Date:

PATIENT HEALTH QUESTIONNAIRE

Patient Name:	Preferred Name:		
Occupation:	Height:	Weight:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Leisure Activities/Hobbies:			
Are you? <input type="checkbox"/> Right-handed <input type="checkbox"/> Left-handed			
Where do you live? <input type="checkbox"/> Private Home <input type="checkbox"/> Apartment/Rented Room <input type="checkbox"/> Assisted Living/Group Home <input type="checkbox"/> Hospice <input type="checkbox"/> Other:			
With whom do you live? <input type="checkbox"/> Alone <input type="checkbox"/> Spouse Only <input type="checkbox"/> Spouse and Others <input type="checkbox"/> Child <input type="checkbox"/> Other:			
Does your home have? <input type="checkbox"/> Stairs, No Railing <input type="checkbox"/> Stairs, Railing <input type="checkbox"/> Ramps <input type="checkbox"/> Uneven Terrain Please Explain:			
How many times have you fallen in the past 12 months?		Did it result in an injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	
During the past month have you been feeling down, depressed, or hopeless or bothered by having little interest or pleasure in doing things? <input type="checkbox"/> Yes <input type="checkbox"/> No			
General Health Status: Please rate your health. <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor			
Please list any known allergies (including medications, latex, etc.) below.			

Please list current medications (including prescription, over the counter, and herbal). You can also provide our office staff a list to copy.

Name	Dosage	Frequency	Please Indicate Route			
			Oral	Patch	Topical	Other
			Oral	Patch	Topical	Other
			Oral	Patch	Topical	Other
			Oral	Patch	Topical	Other
			Oral	Patch	Topical	Other

Surgery / Hospitalization, please include date and reason.

Are you currently experiencing any of the following?

Nausea or Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest Pains (Angina)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Productive/Chronic Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain Wakes Me at Night	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty Swallowing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Fever, Chills, Sweats	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizzy Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty Sleeping	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Visual Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Palpitations	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing Loss/Ringing in Ears	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of Appetite	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty Walking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No
Unusual Weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fatigue or Myalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Joint Pain or Swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unexplained Weight Changes	<input type="checkbox"/> Yes <input type="checkbox"/> No

Social History / Wellness

Do you drink alcoholic beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No
How often have you completed at least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your condition? <input type="checkbox"/> At least 3 times per week <input type="checkbox"/> 1-2 times per week <input type="checkbox"/> Seldom or Never	

Have you been diagnosed with any of the following?			
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis, If Yes, Type:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Respiratory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease/Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Auto Immune Disease If yes, Type:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spinal Cord Stimulator	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Clots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bowel or Bladder Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer, If yes, Site:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Peripheral Vascular Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Currently Pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Speech Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke/TIA	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No

Current Condition
When did this problem(s) first begin?
Describe the problem(s).
Explain how problem(s) occurred.
Have you ever had this problem before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many times?
Are your symptoms worse in the: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night <input type="checkbox"/> Same All Day
How are you taking care of the problem(s) now?
My pain/problem is slowing getting: <input type="checkbox"/> Worse <input type="checkbox"/> Better <input type="checkbox"/> Staying the Same
My symptoms bother me: <input type="checkbox"/> Constantly (100%) <input type="checkbox"/> Most of the Time (75%) <input type="checkbox"/> Occasionally (50%) <input type="checkbox"/> Once in a While (25%)
Do you have any numbness, tingling, or burning? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please check one: <input type="checkbox"/> Constantly <input type="checkbox"/> Intermittently
What functions could you perform before, that you now are unable to do?
Please explain any specific treatment you have received for this problem, such as previous physical or occupational therapy, chiropractic visits, pain medications, etc.
Have you received X-rays, MRI, CT scan, Bone scan for this problem? If so, please list the dates and results.
Are you aware of any physical reason why you should not receive treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please tell us what it is:
What are your goals for therapy?

I will advise the therapist if there is any change in my physical condition which will alter my response to any of the question on this form.

Signature: _____ Date: _____