**PT Your Way & Advanced Specialty Care**
**Patient Registration and Authorization Form**
**Please Print**

**Today's Date:_____ Diagnosis: _____Date of Birth:_____**
**Patient Name: First_____ Last_____**
**Social Security #:_____ Male_____ Female_____ Married___Single___Widowed___**
**Home Address: _____**
**City: _____State:_____Zip Code:_____**
**Phone Numbers: Home: _____ Cell: _____**
**Work:_____ Email Address:_____**
**Employer: _____ Occupation: _____**

**Who can we thank for sending you to PT Your Way? _____**
**M.D. _____ Friend _____ Insurance Co._____Internet _____ Other_____**
**Is this treatment related to an auto accident Yes ___ No ____ If YES, Injury Date_____**
**Have you had any physical/occupational/speech therapy this calendar year? Yes No # of visits_____**

**Referring Physician: _____ Phone #_____**
**Primary Care Physician: _____ Phone # _____**

**Primary Insurance Company:_____**
**Policy Holder: _____ Policy Holder Date of Birth:_____**
**Relationship: _____Social Security #_____ Policy Holder Employer: _____**

**Secondary Insurance Company: _____**
**Policy Holder: _____Relationship: _____**
**Policy Holder Date of Birth: _____Social Security #_____**

**Tertiary Insurance Company: _____Policy Holder:_____**
**Relationship: _____Policy Holder Date of Birth:_____Social Security #_____**

**Workman's Compensation Claim # _____Injury Date : _____**
**Adjuster and Agency_____ Phone # _____**

**Emergency Contact: _____**
**Phone # _____Relationship: _____**
**The undersigned agrees to be ultimately responsible for payment of all charges for services rendered by PT Your Way & Advanced Specialty Care whether or not such services are covered by insurance benefits.** The undersigned agrees to reimburse PT Your Way & Advanced Specialty Care for any expenses, including reasonable attorney fees, incurred in connection with the collection of sums due for services performed hereunder.

Patient/Responsible Party Signature: _____ Date: _____

PHYSICAL THERAPY
YOUR WAY
ADVANCED SPECIALTY CARE

# Policies and Procedures
## Please read and initial each paragraph and sign the last page

Physical Therapy Your Way & Advanced Specialty Care takes the quality of your health care very seriously. Our model enables us to provide the highest level of specialized care possible. Unlike other physical therapy practices, we are proud to offer one-hour individual appointment sessions with a licensed physical therapist who specializes in treating complex conditions. Our patient centered, holistic approach allows exceptional results and a high rate of patient satisfaction.

_____ **(initial) Payment Policy: SELF PAY Patients**
**Our fee is $186.50 for the Evaluation (first) visit and $169 for each followup visit.** Please come prepared to make a payment at each visit. We accept cash, check and major credit cards. **We require a credit card to be maintained on file** for charging visit fees, medical supplies, no show and late cancel fees. You may still pay for patient responsible charges with cash, check or HSA/FSA cards by presenting these at the front desk **prior** to your treatment. At the end of each treatment session, you will receive an itemized bill that you can submit to your insurance company. Although we are here to assist you with understanding your insurance coverage, **any reimbursement from an insurance company is the responsibility of the patient.**

_____ **(initial) Payment Policy: INSURANCE Billing**
I hereby agree to pay any and all charges that are not covered by my insurance plan, such as deductible, coinsurance, copayments, dry needling, medical supplies, no show and late cancel fees. **We require a credit card to be maintained on file** for charging any fees determined to be patient responsibility. You may still pay for patient responsible charges with cash or check prior to your treatment to avoid the charges being run on the credit card on file.

_____ **(initial) Cancellation Policy:**
All appointments require at least **48 hours advance notice on a business day** for any changes or cancellations. *Business hours are from 7:00am on Monday through 2:00pm on Friday, excluding holiday closures.* **If 48-hour notification is not given, you will be charged $60 for the missed appointment. This amount needs to be paid at the time of your cancellation or before your next visit and will be collected directly from your credit card on file.** To cancel a *Monday* or *Tuesday* appointment, please call our office by 2:00 p.m. on *Friday*. If over the weekend you need to cancel a Monday appointment, please leave a message as soon as possible. Text and email cancellations are not valid. Please call the office for ALL appointment cancellations.

_____ **(initial) No Show Policy:**
If you fail to show up for a scheduled appointment, a **$60 no show fee will be charged to your credit card on file.**

_____ **(initial) Same Day Scheduling:** If you no show and/or late cancel **more than twice**, your future appointments will be canceled and you will be placed on **SAME DAY SCHEDULING.** This means you may contact us in the morning of a day you are available to ask for a same day appointment.

_____ **(initial) <u>Late Policy</u>**:
If you think you will be late for your scheduled appointment, please call and inform us. We will try to accommodate you, however your treatment session time may be reduced in order to remain on time for the courtesy of the next scheduled patient. **If you <u>self pay</u> and are late or need to leave early, you will still be charged for your full hour treatment session**. For patients whose **<u>insurance we are billing</u>, a delay in your arrival or an early departure from your scheduled one-hour session will incur a $20 charge for every 10 minutes you are absent.**

_____ (**initial**) **We do understand that unforeseen matters of sickness or emergencies occur that you cannot control. Unfortunately we still need to charge for these missed appointments** in order to continue providing one-hour individual appointment sessions. Thank you for your understanding and cooperation.

_____ **(initial) <u>Appointment Reminders</u>:**
As a courtesy to our clients, we offer automated reminder phone calls, text messages or emails, **however it is ultimately your responsibility to attend your scheduled appointment.** Please be sure that the phone number or email you have provided us is correct in order to receive these reminder messages.

**I prefer to receive appointment reminders by**:

**<u>Please circle ONE</u>: Phone Call Email Text Message None**

Please list the appropriate phone number or email: _____

_____ **(initial) <u>Return Check Fee</u>**:
If checks are returned from the bank there will be a **$20** returned check fee assessed to your account. This amount will be collected directly from your credit card on file.

_____ **(initial) <u>HIPAA</u>**: I have read and understand I have rights to a copy of Physical Therapy Your Way's HIPAA privacy notice. This notice is available upon request and on our website at www.physicaltherapyyourway.net. I have the right to request restrictions on the use of my information and to revoke my consent at a later date.

_____ **(initial)** I understand that I am solely responsible for the balance due on my account. If your account balance matures to over 120 days and remains unpaid, your account will be sent to collections and we will no longer be able to assist you with the account. Any accounts in default and sent to collections could be assessed attorney fees, court costs and interest of 1% per month. We hope this course of action is unnecessary, however we are required to notify you of this information.

Thank you for trusting us with your specialized physical therapy needs. I have read and fully understand the above policies and procedures of Physical Therapy Your Way P.L.C. and agree to these terms.

Signature of Patient/Responsible Party: _____ Date: _____

# PT Your Way
## Patient Health Questionnaire

Date: _____

Patient Name: _____ Height: _____ Weight: _____ Age: _____

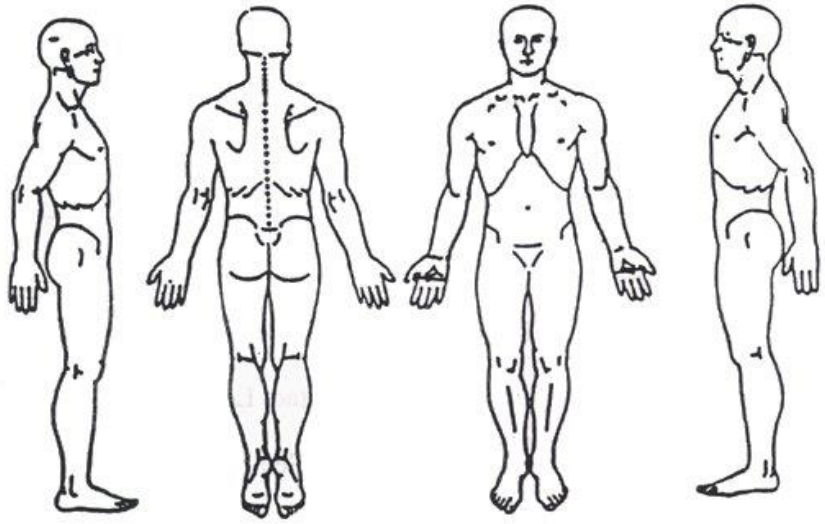
1. Onset of Symptoms/Injury Date_____ Surgery Date (if applicable)_____
2. Describe your symptoms:_____
3. How did your symptoms start or most recently flare-up?_____
   _____
4. During the past week indicate the average intensity of your symptoms on a scale of 0 -10.
   With **0 being NO PAIN** and **10 being UBEARABLE PAIN:** **0 1 2 3 4 5 6 7 8 9 10**

5. During the past week how much has pain interfered with your normal work? (include work outside the house and housework) Please circle:
   **Not at all A little bit Moderately Quite a bit Extremely**

6. Have your symptoms caused you to stop or limit participation in events such as? please circle**;**
   **work church gym recreation other_____**
7. How often do you experience your symptoms? Circle: **Constantly Intermittently**

8. What describes the nature of your symptoms? Circle: **Sharp Shooting Stiffness**
   **Burning Dull ache Weakness Numb Tingling Off balance**

9. How are your symptoms changing? Please Circle **Getting better No Change**
   **Getting Worse Fluctuating Unpredictable**
10. Have you had similar symptoms in the past? **NO YES If so when_____**
11. Please draw below where you have pain or other symptoms?



**Please list your current medications:**

_____

_____

_____

_____

_____

_____

_____

12. Who have you seen for your current symptoms? Circle: **Primary Dr. Specialist No One**
**Chiropractor Acupuncturist Physical Therapist Masseuse Other_____**

13. What tests have you recently had completed for your symptoms?
X-Ray Body part_____ Date_____
MRI Body part_____ Date_____
CT Body part_____ Date_____
Other _____ Date_____

14. What is your current work status? Circle: **Full time Part time Student Retired**
**Homemaker Other_____ Occupation (if applicable)_____**

15. Are any of the following factors contributing to your current condition? Please circle:
**sedentary lifestyle fear avoidance fear of falling vision hearing**
**memory current home environment alcohol use drugs obesity**

16. Please identify up to three important activities that you are unable to do or are having difficulty doing as a result of your current injury or problem. Circle the number on the line that best fits your current ability. **0 being UNABLE TO PERFORM ACTIVITY** and **10 being ABLE TO PERFORM ACTIVITY AT THE SAME LEVEL AS BEFORE INJURY OR PROBLEM.**

| | | UNABLE | | | | | | | | | | ABLE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. | _____ | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| 2. | _____ | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| 3. | _____ | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |

**Medical History**

Please mark Yes or No for each of the following. Any YES answers please explain.

| **Cardiovascular System:** | **Yes** | **No** | **Explain** |
|---|---|---|---|
| Light Headedness | | ___ | ___ _____ |
| Heart disease | | ___ | ___ _____ |
| Pace Maker | | ___ | ___ _____ |
| High Blood Pressure | | ___ | ___ _____ |
| Chest paint with rest | | ___ | ___ _____ |
| Night sweats | | ___ | ___ _____ |
| Shortness of breath | | ___ | ___ _____ |
| Excessive sweating | | ___ | ___ _____ |
| Heartbeat in abdomen when you lie down | | ___ | ___ _____ |
| Leg cramps when walking several blocks | | ___ | ___ _____ |
| **Pulmonary System:** | | | |
| Difficulty or labored breathing | | ___ | ___ _____ |
| Prolonged cough | | ___ | ___ _____ |
| Lung/Asthma | | ___ | ___ _____ |
| Smoke/tobacco use | | ___ | ___ _____ |

| **Blood Born Diseases:** | **Yes** | **No** | **Explain** |
|---|---|---|---|
| HIV | ___ | ___ | _____ |
| West Nile Virus | ___ | ___ | _____ |
| Hepatitis A, B or C | ___ | ___ | _____ |
| Lyme's Disease | ___ | ___ | _____ |
| **Gastrointestinal & Urogenital System:** | | | |
| Diarrhea or constipation | ___ | ___ | _____ |
| Abdominal pain | ___ | ___ | _____ |
| Pain or difficulty when urinating | ___ | ___ | _____ |
| Leak urine w/cough, sneeze or exercise | ___ | ___ | _____ |
| Changes in menstruation pattern (female) | ___ | ___ | _____ |
| Currently pregnant | ___ | ___ | _____ |
| **Endocrine System:** | | | |
| Unexplained weight loss or gain | ___ | ___ | _____ |
| Diabetes | ___ | ___ | _____ |
| Thyroid problems | ___ | ___ | _____ |
| Easy bruising | ___ | ___ | _____ |
| **Nervous System/Musculoskeletal** | | | |
| Have you fallen with injury and/or fallen 2 or more times in the past year? | ___ | ___ | _____ |
| Dizziness | ___ | ___ | _____ |
| Gait or balance disturbances | ___ | ___ | _____ |
| Neurological problems/stoke | ___ | ___ | _____ |
| Abnormal Numbness, pins, needles | ___ | ___ | _____ |
| Muscle weakness | ___ | ___ | _____ |
| Headaches | ___ | ___ | _____ |
| Changes in vision | ___ | ___ | _____ |
| Arthritis /Joint problems | ___ | ___ | _____ |
| Night pain | ___ | ___ | _____ |
| Trauma | ___ | ___ | _____ |
| Morning stiffness | ___ | ___ | _____ |
| Prolonged use of corticosteroids | ___ | ___ | _____ |
| **Integumentary System:** | | | |
| Changes in skin color or nail integrity | ___ | ___ | _____ |
| **General:** | | | |
| Cancer | ___ | ___ | _____ |
| Surgeries | ___ | ___ | _____ |
| Fever/Chills | ___ | ___ | _____ |
| Unusual swelling/edema | ___ | ___ | _____ |
| Other medical conditions | ___ | ___ | _____ |

Any additional explanations: _____

_____