Choice Therapy

Choice Therapy Patient Registration Form

Name **Date:**

Home Address **City**

State **Zip**

Phone Number **Email Address**

Would you prefer to receive appointment reminders by text or email? If text, who is your carrier? ☐ Email ☐ Text **Carrier:**

If under 18, who is responsible for account

Relationship to Patient

Referral Source Name/Address

How did you hear about us? ☐ Friend/Family ☐ Website ☐ Facebook ☐ Google

☐ Prior Patient ☐ Doctor's Order Other:

Primary Health Insurance Company

***REQUIRED regardless of coverage by Workers Compensation, Auto Insurance or Personal Liability Insurance**

Insurance Company Name **Phone**

Member ID # **Group #**

Policyholder Name (if other than patient)

Policyholder DOB **Patient relationship to policyholder**

Secondary Health Insurance Company (if applicable)

Insurance Company Name **Phone**

Member ID # **Group #**

Policyholder Name (if other than patient)

Policyholder DOB **Patient relationship to policyholder**

Workers Compensation, Auto Insurance or Personal Liability Insurance (if applicable)

Medical insurance information is required in case work comp or motor vehicle accident denies you coverage

How were you injured (check one) ☐ Work ☐ Auto ☐ Liability **Date of Injury**

Employer at time of injury

Adjuster's Name **Adjuster's Phone number**

Insurance Carrier Name and Address

Visits ordered by MD **File or Claim Number** **State accident occurred**

Choice Therapy • Authorization to Treat

AUTHORIZATION TO TREAT: I voluntarily consent to therapy care encompassing evaluation and treatment procedures. I acknowledge that no guarantees have been made to me about the results of the exam and/or treatment to be provided in this healthcare facility. I authorize Choice Therapy to provide such treatment. **MY HEALTHCARE PROVIDER, INSURER, OR PLAN MAY REQUIRE A PHYSICIAN REFERRAL OR PRIOR AUTHORIZATION. I MAY BE OBLIGATED FOR PARTIAL OR FULL PAYMENT FOR THERAPY SERVICES RENDERED**.

Initials ☐

PAYMENT AUTHORIZATION: I understand that all balances designated as 'the patient's responsibility' such as co-insurances, co-payments and deductibles are due and payable to Choice Therapy. I agree to pay the charges for the care and treatment rendered to me that are not covered by insurance including any reasonable collection fees required to collect delinquent accounts. As part of working with my insurance carrier, I recognize that Choice Therapy may be provided with information about my insurance coverage, and that on occasion Choice Therapy may share some of this information with me. However, I understand that Choice Therapy is not responsible for the accuracy of any insurance coverage information shared with me, and that I am solely responsible for reviewing my insurance plan and/or working with my insurance carrier to determine the scope and details of any available insurance coverage. This is not a guarantee of benefits.

Initials ☐

If your deductible has not been met or you have a balance, we would be happy to receive payment for your therapy services at each visit.

INSURANCE BENEFITS ASSIGNMENT: I authorize that the payment of my insurance benefits be made directly to Choice Therapy for all services delivered; if I am paid directly I will promptly pay Choice Therapy all monies paid to me.

Initials ☐

HIPAA PRIVACY POLICY: My signature below indicates that I have been given the Notice of Privacy Practices for Choice Therapy. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to Choice Therapy to release any of my protected healthcare information.

Initials ☐

CANCEL/NO SHOW POLICY: We ask that if you are unable to keep your appointment, that a 24-hour notice is given. We do understand emergency situations may arise and just ask that you call as soon as possible. Upon 2 consecutive No Shows, all future appointments will be canceled, and we will require same day visit scheduling. Cancel/no show fees may apply.

Initials ☐

RECORD RELEASE: I am aware that Choice Therapy may release any/all medical information acquired in the course of treatment to myself, my insurance company, employer, QRC or other healthcare agencies, professionals, or persons who may provide healthcare services deemed necessary for continuing my medical care.

Initials ☐

REMINDERS: As a service to patients, we may provide appointment reminder(s) and/or other types of notifications (weather closure, etc). By providing your contact information, you consent to receive such notifications.

Initials _____

Date: _____ **Patient's Printed Name:** _____

Signature of Patient/Patient Representative: _____

If applicable, Patient Representative's name & relationship: _____

REVIEW AND INITIAL BELOW ONLY IF APPROPRIATE:

MEDICARE PATIENTS ONLY: Are you currently, or in the last 30 days, have you received any type of Home Health Services, therapy from a home health care agency, transitional care facility, or nursing home? ☐ Yes ☐ No

If YES, we cannot treat you until you have been discharged. Medicare will not pay our services. You may request Medicare Cap information.

Initials _____

SELF REFERRAL OR OUT OF STATE REFERRAL: I understand that if I have been referred by a physician who is not licensed in the state of MN, and I am being treated at a clinic in MN, I will be considered a Self-Referral and can be treated for 90 days. After that time, if I would like to continue treatment, I will need to obtain an order from a physician who is licensed in the state of MN. The same 90-day rule pertains if I have not been referred by a physician, and I am self-referring.

Initials _____

PAYMENT AUTHORIZATION – SAME DAY PAY: Your services will not be billed to your insurance company or do not qualify for coverage. Charges must be paid in full at the time of service in order to receive the prompt pay discount. The amount charged is determined by the case's complexity. Cost of the evaluation is $110 and follow up is $85. If a supply or orthotic is issued, there will be an additional charge. I do not want my services billed to an insurance company and will not do so myself. (Note: This is not available for anyone who is covered by a government insurance (MA/Medicare/VA)

Initials _____

Choice Therapy • Patient Health History and Information

Dear Patient: This information is considered confidential. In order for us to understand your condition properly, please be as accurate as possible while completing this form. Thank you!

Primary Care Physician:

Date of Birth: **Sex:** ☐ Male ☐ Female ☐ Prefer not to say

Height (X'XX"): **Weight** (lbs): **Dominant Hand:**

FOR WOMEN: Are you currently pregnant or think you might be pregnant? ☐ Yes ☐ No

Recent Surgery: ☐ Yes ☐ No **Date of Surgery:** **Type of Surgery:**

Occupation: **Reason for therapy appointment:**

Please describe below how your injury/problem occurred (i.e. fall, activity, work, auto, unknown)**:**

Date of onset: **Description of onset**:

Other types of treatment for this condition (please check all that apply):

☐ Home Care ☐ Massage ☐ Chiropractor ☐ Specialist Other:

For this condition have you had any of the following? (If yes, please write date; if no, leave blank)

X-ray date:

MRI / CT scan date:

Injection: type: **date:**

Surgery: type: **date:**

Other: **date:**

Have you lost and days of work? ☐ Yes ☐ No

If yes, please explain:

Rate Pain Level (0) is no pain, (10) is worst possible pain

Current Pain

Best pain has been in the last week

Worst pain has been in the last week

What makes your pain better?

What makes your pain worse?

Please indicate your current limitations due to injury:

☐ Sitting	☐ Standing	☐ Sleeping
☐ Sit to stand / Transfers	☐ Walking	☐ Laying Down
☐ Up / Down Stairs	☐ Reaching	☐ Squatting
☐ Bending	☐ Looking Overhead	☐ Taking a breath
☐ Swallowing	☐ Talking / Chewing / Yawning	☐ Turning Head
☐ Driving	☐ Work	☐ Self-care/Hygiene
☐ Home Activities	☐ Repetitive activities	☐ Sports / Recreation

Other:

List two goals for therapy:(ex. Stairs, reaching overhead)

Over the last month my condition is: ☐ Getting Better ☐ Getting Worse ☐ Staying the same ☐ Unstable

Any prior injuries? ☐ Yes ☐ No If yes, please Explain:

Please list current medications:

Are you currently taking blood thinning or anticoagulant medication for any reason? ☐ Yes ☐ No

ALLERGIES:

Are you latex sensitive? ☐ Yes ☐ No

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

I live at my own house (please check all that apply):

☐ Independently ☐ With strong local support ☐ With limited/no local support

☐ I am a caregiver ☐ I am not living in my own house

Do you have an Advanced Directive stating "Do not resuscitate"? ☐ Yes ☐ No

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Have you RECENTLY noted any of the following (check all that apply)?

☐ Changes in appetite	☐ Falls	☐ Pain at night
☐ Changes in bowel or bladder function	☐ Fever/chills/sweats	☐ Shortness of breath
☐ Dizziness/light headedness	☐ Headaches	☐ Weakness/fatigue
☐ Difficulty Swallowing	☐ Nausea/vomiting	☐ Weight loss/gain

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ☐ Anemia
- ☐ Alzheimer's
- ☐ Asthma
- ☐ Cancer
- ☐ Chemical dependency/alcoholism
- ☐ Concussion
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney/liver problems
- ☐ Lung Problems
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker inserted
- ☐ Parkinson's disease
- ☐ Rheumatoid Arthritis
- ☐ Stomach ulcers
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Traumatic Brain Injury
- ☐ Other
- ☐ None

If you selected either Cancer and/or Other, Please list here:

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Link to Choice Therapy Privacy Practices

My signature below indicates that I have been given the Notice of Privacy Practices for Choice Therapy. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law; I must give my written authorization to Choice Therapy to release any of my protected healthcare information.

Patient Name (printed):

Patient Signature: **Date:**