FORZA
PHYSIOTHERAPY & WELLNESS

# Forza Physiotherapy and Wellness

**Patient Registration Form**

Today's Date: _____

**PATIENT INFORMATION:**

Name: First: _____ Middle: _____ Last: _____

Address: _____ City _____ State: _____ Zip: _____

Date of Birth _____ Gender: M | F Social Security # _____

Home Phone: (  ) _____ Mobile Phone: (  ) _____

Email: _____

Emergency Contact Name: _____ Phone: (  ) _____

**PATIENT/GUARANTOR EMPLOYMENT INFORMATION:**

Employer Name: _____ Work Phone: (  ) _____

Occupation: _____ Full-time: _____ Part-time: _____ Other: _____

**REFERRING PHYSICIAN:**

Name: _____ Phone: (  ) _____

**PRIMARY CARE PHYSICIAN:**

Name: _____ Phone: (  ) _____

**ADDITIONAL INFORMATION**

1. Have you received any physical therapy for any condition this year? Yes | No

2. If yes, what condition was treated? _____

3. Are you currently enrolled in Home Health? Yes | No

4. Have you had surgery for this condition? Yes | No If yes, date of surgery? _____

5. How did you hear about us? _____

**PEDIATRIC PROFILE ONLY**

1. Child's Custody Satus: _____ Mother _____ Father _____ Joint _____ Legal Guardian

**Please complete reverse side**

**INSURANCE INFORMATION**

**Insurance Policy Holder/Guarantor Information :**

Name: First: _____ Middle: _____ Last: _____

Date of Birth: _____ Gender: M | F Social Security # _____

Relationship to Patient: Self Spouse Child Other _____

*****SKIP THE SECTION BELOW IF YOU PROVIDED FRONT DESK YOUR INSURANCE CARD*****

**PRIMARY INSURANCE:**

Insurance Name: _____

ID Number: _____ Group Number: _____

**SECONDARY INSURANCE:**

Insurance Name: _____

ID Number: _____ Group Number: _____

**ACCIDENT RELATED INFORMATION *** IF APPLICABLE *****

Nature of Injury: _____ Automobile _____ Work _____ Other: _____

Date of Injury: _____

Name of party responsible for payment: _____

Attorney (If applicable): _____

Contact Person: _____ Phone: ( ) _____

Insurance Company Name: (if applicable) _____ _____

Contact Person: _____ Phone: ( ) _____

Claim no. _____

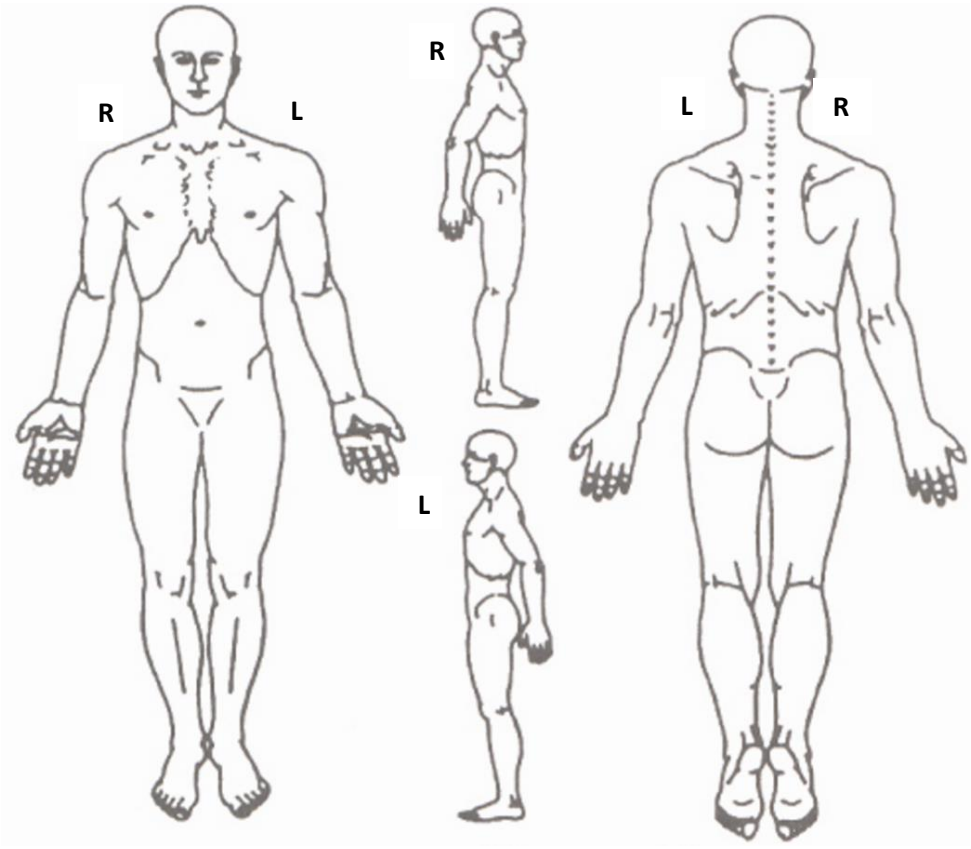
# Medical History

**Patient Name:** _____

**Do you currently have, or have you ever had any of the following?**

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Arthritis/ Rheumatoid Arthritis | ☐ | ☐ | High Blood Pressure | ☐ | ☐ |
| Asthma/ Bronchitis/Pneumonia | ☐ | ☐ | Hepatitis | ☐ | ☐ |
| Bowel/Bladder Problems | ☐ | ☐ | HIV/AIDS | ☐ | ☐ |
| Cancer: _____ | ☐ | ☐ | Osteoporosis | ☐ | ☐ |
| Chest Pain | ☐ | ☐ | Parkinson's Disease | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Stroke/CVA | ☐ | ☐ |
| Emphysema | ☐ | ☐ | Alcohol/Drug Abuse | ☐ | ☐ |
| Epilepsy/Seizures | ☐ | ☐ | Do you have any surgical implants? | ☐ | ☐ |
| Heart Disease/Attack | ☐ | ☐ | Implant Location: _____ | | |
| Head/Neck Trauma | ☐ | ☐ | Do you have a pacemaker/Defibrillator? | ☐ | ☐ |
| Depression/Anxiety | ☐ | ☐ | Females: Are you currently pregnant? | ☐ | ☐ |

**BODY CHART: Please mark with a "X" the areas where you feel pain/symptoms on the chart on the right.**




**Please complete reverse side**

Have you had any of the following for this condition? X-RAY MRI CT SCAN OTHER

Results:_____

Have you had steroid injections to this area? YES NO If yes, how many? _____

Have you had any falls this year? YES NO If yes, how many? _____

Describe the most recent fall: _____

_____

Do you have any current or past health or medical problems that are not listed above?

_____

_____

Are you currently taking blood thinner medication? _____

Are you allergic to adhesive/tape/latex? _____

| | | | |
|---|---|---|---|
| How many days do you exercise a week? | 0-1 | 2-3 | 4 or more |
| How INTENSE is your fitness routine? | MILD | MODERATE | HIGH |
| What type of exercise do you do? | _____ | | |

Please list all major surgeries and the approximate date of the operation related to this condition:

_____

_____

_____

Please list any PAIN medications that you are currently taking:

_____

_____

_____

**Patient/Guardian Signature:** _____

**Guardian Printed Name:** _____

**Date:** _____

# Forza Physiotherapy and Wellness, LLC

# OFFICE POLICIES

## PATIENT AUTHORIZATION

### Consent for Treatment and Authorization to Release Information

I hereby authorize Forza Physiotherapy and Wellness, LLC to provide any physical therapy services or related services as deemed necessary by the physical therapist(s). I consent and authorize Forza Physiotherapy and Wellness, LLC to release all information contained in my medical and financial records, including diagnosis and test results, to:

1. any doctor or other health care provider involved in my care
2. my insurance company or health plan including Medicare
3. any person or entity responsible for paying or processing for payment of any portion of my healthcare bill(s)
4. governmental or accrediting agencies
5. entities utilizing this information for quality management, peer review and or outcome analysis
6. any other person or entity as required or allowed by state and/or federal law

This consent applies to all records created in the course of and relating to this healthcare. To provide the practitioners who will treat me during my care with an access to my prior medical history, I also consent and authorize any health care provider to release medical information contained in my medical records from prior treatment that is relevant to my current care and treatment.

If I am the patient or the patient's legal guardian, I also consent to release billing information and medical records to the patient's primary care physician (PCP) and his/her medical group. This release shall remain valid until I notify the company, in writing, of my desire to revoke it.

### Assignment of Insurance Benefits

I hereby authorize any and all insurance carriers, Medicare, attorneys, agencies, governmental departments, companies, individuals, and/or legal entities ("payers") to pay directly to Forza Physiotherapy and Wellness benefits due me, if any, by reason of services described in the statement rendered.

### Patient Communication

I give consent for Forza Physiotherapy and Wellness, LLC to call, e-mail, or mail my home or other designated locations. Forza Physiotherapy and Wellness, LLC may also leave a message on voice mail or in person in reference to appointments, insurance items and issues pertaining to my clinical care.

### Personal Valuables

I hereby release Forza Physiotherapy and Wellness and its associates of any and all responsibility for loss or damage to personal property, including but not limited to clothing, money, or other valuables kept in my possession or brought in by me or anyone with me during my care.

## STATEMENT OF FINANCIAL RESPONSIBILITY

Forza Physiotherapy and Wellness appreciates the confidence you have shown in choosing us to provide for your rehabilitative needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill.

**Please see reverse side**

You are responsible for payment of any co-payment at the time of service and on receipt of a bill for any deductible /coinsurance as determined by your contract with your insurance carrier. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full.

I have read the above policy regarding my financial responsibility to Forza Physiotherapy and Wellness, LLC for providing rehabilitative services to the patient or me. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Forza Physiotherapy and Wellness, LLC. I agree to pay Forza Physiotherapy and Wellness, LLC the full and entire amount of all bills incurred by me or the patient, if applicable, any amount due after payment has been made by my insurance carrier.

## CANCELLATION AND NO-SHOW POLICY

Forza Physiotherapy and Wellness, LLC strives to provide each patient with the highest quality care while accommodating your schedule. Therefore, we reserve specific time-allotments for each patient. It is critical for you to consistently attend your scheduled appointments in order to achieve the goals that you, your physician, and your physical therapist want you to achieve.

We respectfully request 12-hours advanced notice of any appointment cancellation. If we do not receive advanced notice of a cancellation, our ability to meet the scheduling needs of our other patients is limited.

**If you cancel without a 12-hour notice, you will be charged a $25.00 Fee.**

In addition, if you do not keep your appointments, your treatment program will be terminated after the second consecutive NO-SHOW or third consecutive CANCELLATION and your physician will be notified immediately. We recognize legitimate reasons for missing appointments and keep accurate records of those occurrences, but we need your cooperation in contacting our office as soon as possible when you will be unable to keep your appointments.

Thank you for your cooperation and consideration of our staff and other patients.

**I have read and understand the above information and agree to the terms above.**

**Date**: _____

**Patient Name:** _____

**Guardian Printed Name:** _____
(If Applicable)

**Patient/Guardian Signature:** _____

## Forza Physiotherapy and Wellness, LLC

### ACKNOWLEDGEMENT OF REVIEW OF HIPAA NOTICE OF PRIVACY PRACTICES

I have been offered a copy of this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

_____ _____

Printed Name of Patient or Personal Representative Date

_____

Signature of Patient or Personal Representative

## FOR COMPANY USE ONLY

### Refusal to Sign Acknowledgement of Review of HIPAA Notice of Privacy Practices

The following patient has been offered a copy of the Notice of Privacy Practices but has refused to sign the Acknowledgement of Review of Notice of Privacy Practices:

Patient: _____ Date _____

Reason (if given by patient): _____

_____

_____

_____

_____

Employee Signature:_____ Date:_____