Initial Eval Date:	Today's Date:
Initial Eval Time:	Initials:
Account #:	Therapist:
Location (use location name not number):	

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name:

First: M.I. Last: Gender: M / F

DOB: ________/_______/_________ | SS #: - - | Marital Status: Student: Yes / No

Legal Guardian or Guarantor Information:

First: M.I. Last: Relationship to patient:

DOB: ________/_______/_________ | SS #: - - | Gender: M / F

*****If the patient is minor, enter the address for the legal guardian or guarantor*****

Address: City: State: Zip:

Home Phone: ( ) | Cell Phone: ( ) | Work Phone: ( )

School Name (if student):

Email Address:

Employer Name: Employer Phone:

Employer Address:

Emergency Contact: Phone: ( ) Relationship:

MEDICAL INFORMATION - This section must be completed

Injury Due To (please circle) : Work (State___) Auto (State___) Accident Surgery Other None

Date of Injury/Surgery/Symptoms: ____/_____/_____ Body Part:

Referring Physician Last Name: First Name: Phone:

Referring Physician Address:

Primary Care Physician: Date of Next Physicians Visit:________ / _______ / ________

Have you had any Home Health or therapy elsewhere in the current year? Yes No Where:

INSURANCE INFORMATION

Insurance Type - Circle one: PPO HMO POS MEDICARE AUTO WORK COMP OTHER

Primary Insurance : Phone:

Claims Mailing Address:

ID/Policy/Claim #: Group #: Rel. to Patient:

Subscriber Name: Subscriber DOB:

Subscriber Employer:

Secondary Insurance: Phone:

Claims Mailing Address:

ID/Policy/Claim #: Group #: Rel. to Patient:

Subscriber Name: Subscriber DOB:

Subscriber Employer:

WORK COMP OR AUTO ONLY

Nurse Case Manager / Adjuster Name:

Phone: Fax:

PATIENT REGISTRATION FORM

Patient Name:

First: M.I: Last: DOB:

ATTORNEY INFORMATION

Attorney Name: Phone:

Address:

CONSENT TO RELEASE INFORMATION

I hereby authorize PT Network LLC aka Pivot Physical Therapy and any of its subsidiaries permission to discuss my financial account and/or my therapy treatment with the following individuals other than myself:

Name: Relationship:

Name: Relationship:

HIPAA ACKNOWLEDGEMENT - ALL patients must initial one of the following:

_______ I hereby acknowledge that I have been provided with a copy of the Notice of Privacy Practices

_______ I hereby acknowledge that I have been provided with a copy of the Notice of Privacy Practices, but decline to accept it at this time

Preferred Method of Contact: _____Home _____Cell _____Work _____ Email (must be provided above)

Do you give permission for us to leave a message: ______ Yes _____ No

CANCELLATION & NO SHOW

It is expected that you actively participate in the recovery process and give 100% effort toward the goals established by you, your therapist and your doctor. Your attendance is critical to the success of your program, therefore, missed appointments may be reported to your physician, insurance carrier, employer, and vocational counselor. Additionally, if I fail to show for a scheduled visit or to reschedule any visit within 24 hours prior to the scheduled time, I may be charged a No Show/Cancellation fee.

______ I hereby acknowledge that I have read and understand the above statement regarding the No Show/Cancellation Fee

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS

I hereby authorize PT Network LLC referred to herein as "Pivot Physical Therapy" and any subsidiary to administer treatment required for my diagnosis, to apply for benefits from my insurance carrier(s) listed able, and I authorized payment of the medical benefits directly to Pivot Physical Therapy, if any, otherwise payable to me for services rendered by Pivot Physical Therapy. Further, I authorized Pivot Physical Therapy to disclose complete medical information concerning the diagnosis for which I am being seen to any other payer or collateral that will pay part or all of these medical bills.

________ I also understand that it is my responsibility to know my insurance benefits and coverage limitations and will be responsible for any service that my insurance carrier does not cover.

I understand that all financial obligations for services are due from me when treatment is rendered. I also understand that I am completely responsible for medical treatment, including any fees charged for returned checks, regardless of any payer, third-party interest, or the resolution of any legal action or lawsuits in which I may be involved. I further understand that Pivot Physical Therapy reserves the right to pursue delinquent accounts via third -party collection agencies or attorneys. In the event my bill is referred for collection, I agree to pay all collection agency fees, attorney fees, court costs, service of process fees and any late charges per month for all balances over 30 days, in addition to the amount owed for services rendered (as applicable by state guidelines). This agreement is a contract under seal and shall be considered a specialty.

Signature of Patient or Responsible Party **Relationship to Patient** **Date**

TREATING ATHLETES

If you are an athlete, by signing below, you give permission for us to send your Plan of Care to the Athletic Trainer at your school if it is requested.

Signature of Patient or Responsible Party **Relationship to Patient** **Date**

PATIENT REGISTRATION FORM

Patient Name:

First: M.I: Last: DOB:

VIRGINIA PATIENTS ONLY - DIRECT ACCESS CONSENT

Legal Full Name (please print or type)

First: M.I. Last: Suffix or Maiden:

Address: City: State: Zip:

Contact Phone Number: ( ) Alternate Phone Number: ( )

Email Address:

Patients Chief complaint (why patient is seeking physical therapy care):

Please Circle One Option Below:

A) I am not under the care of a medical practitioner for the symptoms listed on this form and wish to seek physical therapy care at this time.

B) I am under the care of a medical practitioner for the symptoms listed on this form and wish to seek physical therapy care at this time. Pivot Physical Therapy will provide this practitioner with a copy of the initial evaluation including a patient history within 14 days.

Practitioner's Full Name:

First: Last: Suffix:

Address: City: State: Zip:

Contact Phone Number: ( ) Fax Number: ( )

Email Address:

Signature of Patient or Responsible Party **Relationship to Patient** **Date**

DIRECT ACCESS - All Other States

By signing below, you are giving us approval to send a copy of your medical records to your PCP or physician.

Referring Physician Last Name: First Name: Phone:

Referring Physician Address:

Signature of Patient or Responsible Party **Relationship to Patient** **Date**

PHOTO & VIDEO RELEASE

I hereby grant Pivot Physical Therapy permission to the rights of photographs and/or video recordings of me without payment or any other consideration. I understand that my image or video may be edited, copied, exhibited, published or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area.

Photographic, audio or video recordings may be used for the following purposes: conference presentations, educational presentations or courses, informational presentations, on-line educational courses and educational videos. By signing this release I understand this permission signifies that photographic or video recordings of me may be electronically displayed via the Internet or in the public educational setting. I will be consulted about the use of the photographs or video recording for any purpose other than those listed above.

There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed. This release applies to photographic, audio or video recordings collected as part of the sessions listed on this document only. By signing this form I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

Signature of Patient or Responsible Party **Relationship to Patient** **Date**

If individual photographed/recorded is under eighteen (18) years old, the following section must be completed: I have read and I understand this document. I understand and agree that it is binding on me, my child (named above), our heirs, assigns and personal representatives. I acknowledge that I am eighteen (18) years old or more and that I am the parent or guardian of the child named above.

Signature of Patient or Responsible Party **Relationship to Patient** **Date**