PROactive
PHYSICAL THERAPY SPECIALISTS
A MEMBER OF THE CONFLUENT HEALTH FAMILY

Patient Registration Form - Medicare

Patient Name:	Name You Go By:
Address, City, State, Zip:	
DOB:	Social Security #:
Email Address:	
Home Phone:	Appointment Reminder Method
Cell Phone:	□ Home Phone □ Cell Phone
Work Phone:	□ Work Phone □ Email

By providing my above contact information and signing below, I consent and authorize ProActive PTS and its related entities, agents, contractors, including but not limited to scheduling, billing, and other departments to use automated telephone dialing systems, SMS text messaging, and electronic mail to (1) provide messages (including prerecorded messages or text messages) to me about appointment reminders, patient surveys, my account, payment due dates, missed payments, information for or related to medical goods and/or therapy services provided, exchange information, changes to health care law, health care coverage, care follow-up, and other healthcare information or (2) provide messages (including pre-recorded messages) during a call or via text message that delivers a 'health care' message made by, or on behalf of, a 'covered entity' or its 'business associate' as those terms are defined in the HIPAA Privacy Rule, 45 CFR 160.103. This consent is not required to access any services from ProActive PTS. I understand that I may opt out by calling ProActive PTS.

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Partner's Name:
Financial Responsibility: ☐ Self ☐ Other, Please List:	
2nd Contact Name/Address:	
2nd Contact Phone:	Relation:
General Physician:	Referred By:

Have you had Physical Therapy treatment since January of this year? ☐ Yes ☐ No If yes, # of Visits:
Have you had Chiropractic treatment since January of this year? ☐ Yes ☐ No If yes, # of Visits:
Have you had Home Healthcare in the last 30 days? ☐ Yes ☐ 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 ProActive PTS 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 ProActive PTS. I authorize the filing of claims to my insurance plan and authorize ProActive PTS 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

Patient name:

Release of Information

I hereby authorized ProActive PTS to discuss my personal healthcare information regarding my treatment including diagnosis/prognosis and/or billing and payment for services rendered on my behalf to the person(s) listed below.

Name (print)	Relationship	Phone number
Name (print)	Relationship	Phone number
Name (print)	Relationship	Phone number

Patient/Guardian Signature: Date:

Financial Policy

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.

ProActive PTS requires 24-hour notice for ALL cancellations. Any appointment canceled within 24 hours of the scheduled time will be considered a late cancelled appointment.

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 10 minutes after your scheduled appointment time, we may ask you to reschedule.
- 3 "no show" and/or late canceled appointments will 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 ProActive PTS and its affiliated entities, and its representatives and employees (collectively the "Company") the right to take photographs and/or videos of me inconnection 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:

MEDICARE SECONDARY PAYER (MSP) FORM

Patient Name:

Part I

1. Are you receiving benefits under the Black Lung Program? If yes, date benefits began: _____	☐ Yes	☐ No
2. Was this injury/illness due to a work-related accident/condition? If yes, date of injury/illness: _____	☐ Yes	☐ No
3. Was the injury/illness covered under no-fault (and/or medical-payment coverage) including premises or automobile? If yes, date of accident: _____ Is no-fault insurance available?	☐ Yes ☐ Yes	☐ No ☐ No
4. Was this injury/illness related to an accident in which you intend to file liability suit or litigation pending? If yes, please provide: Attorney's Name: _____ Address: _____ Phone Number: _____ If you answered **NO** to all questions, go to Part II. If you answered **YES** to any of the questions above, Medicare is the secondary payer, you do not need to go to Part II. Please provide primary insurance information.	☐ Yes	☐ No

Part II

1. Are you entitled to Medicare based on? *Check the box that applies.*
   - ☐ Age (65 & older) – go to question #2
   - ☐ Disability – go to question #2
   - ☐ End Stage – Go to **Part III**

2. Do you have group health plan (GHP) coverage based on your own current employment, or the current employment of either your spouse or another family member? If yes, based upon if you are 65 & over or disabled, how many employees, including yourself or spouse, work for the employer from whom you have GHP coverage:	☐ Yes	☐ No
☐ Aged (65 & over) - If you are aged and there are 20 or more employees, <u>your GHP is primary.</u>	☐ Yes	☐ No
☐ Disability - If you are disabled and your employer, spouse, or family members employer, has 100 or more employees, <u>your GHP is primary</u>.	☐ Yes	☐ No

Part III

Medicare benefits are secondary to benefits payable under a GHP for individuals eligible for or entitled to benefits on the basis of ESRD during a period of up to 30-month period if Medicare was not the proper primary payer for the individual on the basis of age or disability at the time that this individual became eligible or entitled to Medicare on the basis of ESRD.

1. Do you have group health plan coverage?	☐ Yes	☐ No
2. Are you within the 30-month coordination period?	☐ Yes	☐ No

If yes to BOTH questions, GHP is primary during the 30-month coordination period.

Please provide a copy of your group health insurance if determined to be primary.

Signature of Patient/Representative:	Date:
Relationship to Patient:	

PATIENT HEALTH QUESTIONNAIRE

Patient Name: **Name You Go By:**

What are your pronouns? ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other:

Do you think of yourself as: ☐ Male ☐ Female ☐ Transgender
☐ Neither exclusively male nor female ☐ Additional gender category, please specify:
☐ Decline to Answer

What sex was originally listed on your birth certificate? ☐ Male ☐ Female ☐ Decline to Answer
For billing purposes, it is helpful to know gender assigned at birth. There can be confusion when a patient legally changes their birth certificate to the gender they align with, but insurance companies' data is lagging.

Occupation: Height: Weight:

Leisure Activities/Hobbies:

Are you? ☐ Right-handed ☐ Left-handed

Where do you live? ☐ Private Home ☐ Apartment/Rented Room ☐ Assisted Living/Group Home
☐ Hospice ☐ Other:

With whom do you live? ☐ Alone ☐ Spouse Only ☐ Spouse and Others ☐ Child
☐ Other:

Does your home have? ☐ Stairs, No Railing ☐ Stairs, Railing ☐ Ramps ☐ Uneven Terrain
Please explain:

How many times have you fallen in the past 12 months? Did it result in an injury? ☐ Yes ☐ No

During the past month have you been feeling down, depressed, or hopeless or bothered by having little interest or pleasure in doing things? ☐ Yes ☐ No

General Health Status: Please rate your health. ☐ Excellent ☐ Good ☐ Fair ☐ 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	☐ Yes ☐ No	Chest Pains (Angina)	☐ Yes ☐ No
Productive/Chronic Cough	☐ Yes ☐ No	Pain Wakes Me at Night	☐ Yes ☐ No
Difficulty Swallowing	☐ Yes ☐ No	Recent Fever, Chills, Sweats	☐ Yes ☐ No
Dizzy Spells	☐ Yes ☐ No	Difficulty Sleeping	☐ Yes ☐ No
Headaches	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Visual Problems	☐ Yes ☐ No	Heart Palpitations	☐ Yes ☐ No
Hearing Loss/Ringing in Ears	☐ Yes ☐ No	Loss of Appetite	☐ Yes ☐ No
Difficulty Walking	☐ Yes ☐ No	Incontinence	☐ Yes ☐ No
Unusual Weakness	☐ Yes ☐ No	Fatigue or Myalgia	☐ Yes ☐ No
Joint Pain or Swelling	☐ Yes ☐ No	Unexplained Weight Changes	☐ Yes ☐ No

Social History / Wellness

Do you drink alcoholic beverages? ☐ Yes ☐ No Do you use tobacco? ☐ Yes ☐ 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? ☐ At least 3 times per week ☐ 1-2 times per week ☐ Seldom or Never

Patient Name:

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

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? ☐ Yes ☐ No If yes, how many times?
Are your symptoms worse in the: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Same All Day
How are you taking care of the problem(s) now?
My pain/problem is slowing getting: ☐ Worse ☐ Better ☐ Staying the Same
My symptoms bother me: ☐ Constantly (100%) ☐ Most of the Time (75%) ☐ Occasionally (50%) ☐ Once in a While (25%)
Do you have any numbness, tingling, or burning? ☐ Yes ☐ No If yes, please check one: ☐ Constantly ☐ 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? ☐ Yes ☐ 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 questions on this form.

Signature: _____ Date: _____