**Therapy Center North INC., DBA Therapy Center East Patient Registration Form**

Name: Last First M Suffix DOB: \_\_\_/\_\_\_/\_\_\_\_\_ Sex: M F SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: Single / Married / Divorced / Widowed / Separated / Domestic Partner / Minor Child

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information:**

Primary Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber name and DOB (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber name and DOB (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Office Policy**

**Consent for Care & Treatment:** Your Physical Therapist will complete an evaluation by examination and interview. An individual treatment program will then be designed. A variety of treatment techniques may be used. I, the undersigned, do hereby agree and give my consent for Therapy Center North Inc., DBA Therapy Center East to furnish physical therapy care and treatment deemed necessary and proper in evaluation and/or treating my physical condition.

**Assignment of Insurance Benefits**: I hereby authorize Therapy Center North Inc., DBA Therapy Center East to furnish information to my insurance carrier(s) concerning this treatment and hereby assign all payment for services rendered.

**Financial Policy:** We bill your personal insurance carrier solely as a courtesy to you. You are responsible for your bill. We require that arrangements for payments of your estimated share be made today. If your insurance carrier does not remit payment to us within 90 days, the balance owed will be due in full from you. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you by your insurance company for services billed by us, you recognize and will honor any obligations to promptly remit the payment(s) to us. If formal collections procedures become necessary, you will be responsible for any additional costs incurred. Your insurance benefits, as quoted to us by your insurance carrier, have been reviewed with you. We assume no liability for any errors made by your insurance carrier in this quotation. We have reviewed these benefits with you and you agree to pay your portion of this bill.

**The above information has been reviewed by me and I understand my responsibility for my account.**

**Consent for Treatment of a Minor**: As parent and/or legal guardian, I authorize Therapy Center North Inc., DBA Therapy Center East to treat the minor patient named on the attached forms while I am not present.

**Cancellation & No-Show Policy:** Appointment times are given to patients to guarantee proper treatment time, with other patients’ care in mind. We reserve the right to charge $35 for any missed appointment without 24 proper notice. If you have a scheduled appointment that cannot be kept, a 24 hour advance notice is needed to avoid this charge. The charge will be the responsibility of the patient, NOT the insurance company. \_\_\_\_\_\_\_\_\_\_ **Patient’s Initials**

Patient/Parent/Guardian Signature Date

Personal Representative Printed Name Date

**Therapy Center North Inc., DBA Therapy Center East**

**Notice of Privacy Practices**

(Effective April 14, 2003)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

**USES AND DISCLOSURE OF YOUR MEDICAL INFORMATION**

**For treatment**: We may use medical information about you to provide you with medical treatment or services. **For payment**: We may use and disclose medical information about you so that the treatment and services you receive at our practice may be billed and payment may be collected from you, your insurance company, and/or a third party. **For healthcare operations**: We may use and disclose health information about you for operations of our healthcare practice. **For individuals involved in your care or payment for your care**: We may release medical information about you to a friend or family member who is involved in your medical care or payment of your account. **For health-related services and treatment alternatives:** We may use and disclose health information to tell you about health-related services or recommend possible treatment options and/or alternatives that may be of interest to you. **As required by law**: We will disclose medical information about you when required by local, state, or federal law. **To avert serious threat to health or safety**: We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. **For military and veterans**: If you are a member of the Armed Forces, we may release medical information about you as required by military command authorities. **For Worker’s Compensation**: We may release medical information about you to Worker’s Compensation or similar programs as necessary. **For public health risks**: We may disclose medical information about you for public health activities. **For health oversight activities**: We may disclose medical information to a health oversight agency for activities authorized by law. **For lawsuits and disputes**: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. **For law enforcement**: We may release medical information if asked to do so by law enforcement officials. **For coroners, medical examiners, and funeral directors**: We may release medical information to a coroner or medical examiner. **For national security and intelligence activities**: We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and/or other national security activities authorized by law. **For protective services for the president and others**: We may disclose medical information about you to authorized federal officials so that they may provide protections to the President, other authorized persons or foreign heads of state or conduct special investigations. **For inmates**: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correct institution or law enforcement official.

**YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION**

**Your right to inspect and copy**: To inspect and obtain a copy of your medical information, you must submit your request in writing. We may deny your request to inspect and copy, in limited circumstances. If you are denied access to medical information, you may request, in writing, that the denial be reviewed**. Your right to amend**: If you feel that medical information we have for you is incorrect or incomplete, you may request an amendment in writing. Your request may be denied if you do not include a reason to support the request**. Your right to an accounting of disclosures**: You have the right to request, in writing, a list accounting for any disclosures of your medical information, except for uses and disclosures of treatment, payment, and healthcare operations as previously described. **Your right to request restrictions**: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or healthcare operations. **We are not required to agree to your request**. **Your right to request confidential communications**: You have the right to request, in writing that we communicate with you regarding medical matters in a certain way or at a certain locations. **Your right to a paper copy of this notice**: You have the right to obtain a paper copy of this notice at any time.

**Changes to this notice:** We reserve the right to make changes to this notice. If so, we will post the current notice in our facility.

**Complaints**: If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services.

**Other uses of medical information**: Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If your revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures already made with your permission and that we are required to retain care provided for you in our records.

**By signing my signature below, I acknowledge that I received and understand the Notice of Privacy Practices.**

Patient or Personal Representative Signature Date

**Therapy Center North Inc., DBA Therapy Center East**

**Medical History:**

Age:\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_ Next Doctor’s Appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Injury/Condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Onset/Injury Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was surgery required? Yes / No Location and Date of Procedure (If applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of procedure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you received chiropractic treatment this year? Yes / No

Describe any previous treatment for this condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**In the section below, please circle any answers that apply:**

**Have you had any imagine performed? Have you recently noted:**

X-ray Weight loss/gain Nausea/Vomiting Fatigue

MRI Weakness Fever/Chills/Sweats Numbness/Tingling

Ultrasound Pregnant/IUD Headaches Change in vision or hearing

CT Scan Pain at night Cramps in legs when walking Insomnia

Doppler Arthritis Ear problems Dizziness

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

Surgeries

Sprains/Strains

Heart Problems

Circulation Problems/Clots

Easy Bruising/ Bleeding

Indigestion/Heartburn

Loss of Consciousness/ Seizures

Diabetes

Cancer

Asthma/ Breathing Problems

Leg/Ankle Swelling

Dizziness

Head Injuries/Stroke

Fractures

Blood Pressure Problems

Motor Vehicle Accidents

Lung Disease

Urinary Problems/Infections/Incontinence

Allergies/ Skin Sensitivity

Do you have any previous injury/disease that may affect current care? Yes No

If yes, please explain and include applicable dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking any medications? Yes No

Name/Type of Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you hope to gain from physical therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What physical and/or fitness goals do you hope to achieve? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any other questions and/or concerns that you would like to share with your physical therapist? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient or Personal Representative Signature Date**

**Therapy Center North Inc., DBA Therapy Center East**

**Please circle any word(s) that describe the pain you are experiencing. Also, please complete the diagram to show where the pain occurs using they key for specific types of pain you feel in those areas.**



1. Flickering, pulsing, quivering, throbbing, beating, and pounding
2. Jumping, flashing, shooting
3. Pricking, boring, drilling, stabbing
4. Sharp, gritting, lacerating
5. Pinching, pressing, gnawing, cramping, crushing
6. Tugging, pulling, wrenching
7. Hot, burning, scalding, searing
8. Tingling, itching, stinging
9. Dull, sore, hurting, aching, heavy
10. Tender, tight, rasping, splitting
11. Tiring, exhausting
12. Sickening, suffocating
13. Fearful, frightful, terrifying
14. Punishing, grueling, cruel, vicious, killing
15. Wretched, binding
16. Annoying, troublesome, miserable, intense unbearable
17. Spreading, radiating, penetrating, piercing
18. Tight, numb, squeezing, drawing, tearing
19. Cool, cold, freezing
20. Nagging, nauseating, agonizing, dreadful, torturing

Key: Pins and Needles= 00000 Stabbing= /////

Burning=xxxxx Deep Ache= zzzzz