Date:

Patient Registration Form

Patient Information

Last Name:	First Name:
Address:	State:
City:	DOB:
Zip:	Social Security:
Contact	
Home Phone: ()	Email:
Work Phone: ()	
Cell Phone: ()	

Emergency Contact

Last Name:	First Name:
Phone: ()	
Relationship:	

Employer Information

Name:	State:
Address:	Suite of Office Number:
City:	
Zip:	

Primary Insurance

Insurance:	ID Number:
Group Number:	Max Annual Benefit:
Deductible:	
Copay: None	
Subscriber Information	
Subscriber Name:	
Subscriber Date of Birth:	
Subscriber Relation to Patient:	

Secondary Insurance

Insurance	ID Number:
Group Number:	Max Annual Benefit:
Deductible:	
Copay: None	
Subscriber Information	
Subscriber Name:	
Subscriber Date of Birth:	
Subscriber Relation to Patient:	

Signed By ______________________ Date ______________

Medical History

Patient Name: Patient Number:

Date condition began ____________________ Date of Surgery (if applicable) ____________________

Type of Surgery (if applicable) ____________________

How did you hear about us? ____________________

What are you therapy goals? ____________________

Height:______ _____ inches Weight:_________lbs

Which apply to your situation?

- ☐ Work related injury
- ☐ Motor vehicle accident
- ☐ Recurrence of previous injury
- ☐ Injury related to lifting
- ☐ Athletic/recreational injury
- ☐ Injury related to falling
- ☐ Cause unknown
- ☐ Attorney involvement

Yes	No	
☐	☐	Are you currently working?
☐	☐	Have you had therapy in the past 12 months?
☐	☐	Are you currently receiving home care?
☐	☐	Are you seeing a chiropractor?
☐	☐	Do you participate in regular exercise/sporting activities?
☐	☐	Have you had X-rays for this injury?
☐	☐	Have you had an MRI for this injury?
☐	☐	Have you had injections for this injury?
☐	☐	Have you had any other treatment /tests for this injury?

Rate your symptom intensity in the past 5 days: Symptoms at worst = _________ out of 10

(0 is no pain or symptoms and 10 is worst possible pain or symptoms) Symptoms at best = _______ out of 10

How many times have you fallen in the past 12 months? ____________________

Yes	No	
☐	☐	Have any falls resulted in injury?

Do you have a history of:

Yes	No		Yes	No		Yes	No	
☐	☐	Diabetes	☐	☐	Rheumatoid arthritis	☐	☐	Depression
☐	☐	Chest pain/angina	☐	☐	Osteoporosis/osteopenia	☐	☐	Anxiety
☐	☐	High blood pressure	☐	☐	Weakness	☐	☐	Smoking
☐	☐	Heart disease	☐	☐	Headaches	☐	☐	If female, are you pregnant?
☐	☐	Heart attack	☐	☐	Concussions	☐	☐	Cellulitis/lymphedema
☐	☐	Heart palpitations	☐	☐	Vertigo	☐	☐	Seizures/epilepsy
☐	☐	Pacemaker/defibrillator	☐	☐	Asthma/breathing problems	☐	☐	Visual impairment
☐	☐	Stroke/TIA	☐	☐	COPD/lung disease	☐	☐	Hearing impairment
☐	☐	Shortness of breath	☐	☐	Thyroid problems	☐	☐	Hernia
☐	☐	Blood clotting disorder	☐	☐	Liver gall bladder problems	☐	☐	Latex allergy
☐	☐	Cancer	☐	☐	Hepatitis/HIV	☐	☐	Other allergies
☐	☐	Recent fractures	☐	☐	Kidney problems	☐	☐	Auto-Immune Disorder (list)
☐	☐	Joint replacement	☐	☐	Parkinson's Disease	☐	☐	Other Neurologic Conditions (list)
☐	☐	Arthritis	☐	☐	Multiple sclerosis	☐	☐	Surgeries (list)

Other conditions not listed: ____________________

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In the past 3 months have you experienced:

Yes	No		Yes	No		Yes	No	
☐	☐	Change in health	☐	☐	Repiratory infection	☐	☐	Fever/chills/sweats
☐	☐	Unexpected weight change	☐	☐	Dizziness/fainting	☐	☐	Change in bowel/bladder function
☐	☐	Numbness/tingling	☐	☐	Sexual dysfunction	☐	☐	Change in appetite
☐	☐	Urinary tract infection	☐	☐	Nausea/vomiting	☐	☐	Other allergies (list)

MEDICATION LIST			
MEDICATION	DOSAGE	METHOD	FREQUENCY
		Oral Patch Inhaler Injection	1x/day 2x/day 3x/day
		Other:	Other:
		Oral Patch Inhaler Injection	1x/day 2x/day 3x/day
		Other:	Other:
		Oral Patch Inhaler Injection	1x/day 2x/day 3x/day
		Other:	Other:
		Oral Patch Inhaler Injection	1x/day 2x/day 3x/day
		Other:	Other:
		Oral Patch Inhaler Injection	1x/day 2x/day 3x/day
		Other:	Other:
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		Other:	Other:
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		Other:	Other:
		Oral Patch Inhaler Injection	1x/day 2x/day 3x/day
		Other:	Other:
		Oral Patch Inhaler Injection	1x/day 2x/day 3x/day
		Other:	Other:
		Oral Patch Inhaler Injection	1x/day 2x/day 3x/day
		Other:	Other:
		Oral Patch Inhaler Injection	1x/day 2x/day 3x/day
		Other:	Other:
		Oral Patch Inhaler Injection	1x/day 2x/day 3x/day
		Other:	Other:

Payment for Services Rendered

As a courtesy to you, we have contacted your insurance company to inquire about therapy benefits. This information is in no way presented to you as a guarantee of coverage by Ivy Rehab and/or its affiliates and is provided only as a general assistance to you. The contact made by this office to your insurance company does not guarantee that your insurance company gave our representative accurate information. If you have concerns about your coverage, it is your responsibility to verify your coverage with your insurance company.

Payment for services are expected at each visit unless prior arrangements have been made. For your convenience, we will securely store your credit card or electronic check on file. When you have a patient responsible balance (copay, co-insurance, deductible, etc.), your electronic payment on file can be charged. A payment (electronic or paper) received with insufficient funds (NSF) or declined credit card will be subject to $25 NSF processing fee in addition to the original amount of payment. Full payment, including fee is expected within 15 days.

Any outstanding unpaid patient balance will be billed to the patient with payment due within sixty days. If said balance is not paid within thirty days, Ivy Rehab and its affiliates reserves the right to forward your balance to a collection agency.

Ivy Rehab and/or its affiliates will be submitting your rendered services to the insurance carrier information you provided to us. As a result, you will be receiving an “Explanation of Benefits” (EOB) statement from your insurance company. An “Explanation of Benefits” is not a bill. It is a statement from your insurance carrier informing you of the charges submitted on your behalf and how the charges were processed. It is the patient's responsibility to work closely with us to obtain reimbursement for services rendered. This will ensure that you will not be billed for charges that should have been paid by your insurance carrier.

Assignment of Benefits

Ivy Rehab and/or its affiliates will work with its patients to attempt to resolve problems and questions regarding charges and payment for services. The patient authorizes Ivy Rehab and its affiliates to obtain counsel and enter legal action on patient’s behalf. Please understand that any uncovered services, such as patient deductibles, co-pays or services rejected by insurance, are the patient's responsibility to pay at the time of service or within sixty days of denial by the insurance carrier. The patient agrees and acknowledges that any checks received directly from the insurance carrier for services rendered by the provider will be immediately forwarded to Ivy Rehab and/or its affiliates upon receipt**. IT IS THE RESPONSIBILITY OF THE PATIENT/INSURED TO CONTACT THE INSURANCE CARRIER REGARDING THE COVERAGE THEY HAVE FOR THERAPY SERVICES, NOT THAT OF THIS OFFICE. ALL PATIENTS ARE RESPONSIBLE FOR THEIR OWN ACCOUNTS.** For and in consideration of services rendered to by Ivy Rehab and/or its affiliates, I hereby agree to pay the full bill for all charges which are not paid to Ivy Rehab and/or its affiliates by insurance carriers, Worker’s Compensation, Motor Vehicle Accident or any balance due which is not covered by insurance or excluded by a copay, deductible and/or co-insurance clause. Further, I assign to Ivy Rehab and its affiliates my right to payment for treatment services rendered to me by Ivy Rehab and/or its affiliates out of the proceeds of any judgement or settlement in my case, and, as applicable, from any insurer (i.e., Medicare, private insurers, other health plans, etc.) providing coverage to me for such expenses.

Missed Appointments

Ivy Rehab and its affiliates are committed to help you achieve your therapy goals as quickly as possible. Professional therapists are scheduled for each of your appointments. We expect all patients to keep appointments and be timely. Telephone notice of cancellations is required. 24-hour notice of cancellation is requested. **Any missed visit will be subject to a no show or cancellation fee**. After three missed appointments Ivy Rehab and its affiliates reserves the right to discontinue services.

______________________________________ __________________

Signed By Date

Consent for Treatment

I consent to the evaluation and treatment by Ivy Rehab, its affiliates, and their respective health care professionals. The clinical provider will explain the nature and purpose of the therapeutic treatment plan and course of treatment. The clinical provider will inform you of expected benefits, complications, and risks of your treatment plan. You have the right to discuss alternatives to the proposed treatment, as well as the consequences of no treatment. Ivy Rehab's affiliated clinicians may use palpation techniques during their evaluation to help determine problems and to find the best treatment plan. Palpation is the act of using hands to examine a body part. Palpation usually involves direct skin-to-skin contact; the therapist's hands are used to press into the skin and tissue to assess the patient's condition. Certain conditions may require palpation in private or semi-private areas of the body. Based on your condition, palpation may require exposure of private parts of the body, like the abdomen, chest, hips, buttocks, or pelvic floor.

Authorizations/Consent

I hereby authorize Ivy Rehab's affiliated health care professionals, and students to provide physical, speech, occupational therapy and/or applied behavioral therapy treatment and medical care. I have been informed of risks and complications that may occur and alternatives that may be available. I acknowledge that no assurances have been made concerning the results intended from my treatment.

Notice of Privacy Practices

Ivy Rehab and its affiliates has established privacy practices. These privacy practices are outlined and posted in the waiting area. A copy of our privacy practices is offered to you at the time of your initial visit to our office. If you require further clarification regarding these privacy practices, please ask at any time. By signing below, I agree that I have read and understand the above stated policies and Ivy Rehab Network and/or its affiliates has provided me with a copy of their Notice of Privacy Practices.

Email/Text

We are committed to keeping your email address confidential. The signature confirms that providing your email, you agree to receive email communications and you are made aware of and accept the possible risks of using unencrypted email. We will never share or sell your email with any third party. We will only use your email address solely to provide timely information about Ivy Rehab and/or its affiliates for treatment/payment/healthcare operations purposes. If the use of unencrypted email is unacceptable to you, you may request other means of communicating with Ivy Rehab and/or its affiliates such as by more secure electronic methods.

I grant permission and consent to Ivy Rehab network, Inc., its affiliates, and third party collection agents or vendors (1) to contact me by phone at any number associated with me including wireless cell numbers, (2) to leave answering machine and voicemail messages for me about information required by law (including debt collection laws) and/or regarding amounts owed by me, (3) to send me a text messages or emails using any email addresses I provide and, (4) to use pre-recorded/artificial voice messages and/or automatic dialing device (an auto-dialer) in connection with any communications made to me or any related scheduled services and my account(s).

I am expressly consenting to receive text and/or email and/or phone call/voicemail communications. I may opt out at any time. In addition to this consent, I confirm that my provided demographic information is accurate.

______________________________________ __________________

Signed By Date