Action Physical Therapy, LLC
200 Main Street
Halstead, KS 67056
316-835-7013
rcookactionpt@gmail.com

Welcome to Action Physical Therapy, LLC. We are very thankful you chose us for your physical therapy needs. The goal at Action Physical Therapy is to return you to the most functional individual you can be through personalized care.

What to expect:

- Assist in managing your health insurance requirements and checking your benefits.
- Dedicate an exclusive appointment time for you in order to provide one-on-one professional care.
- Understand your physical concerns and develop an individualized treatment program to achieve your goals.
- Strive through physical therapy interventions to achieve the best outcome.

The following is our registration packet. It may seem like a lot, but it is important in order for us to best serve you. We appreciate you filling it out accurately.

If you have any concerns, please ask to speak to me specifically or feel free to email or call.

Action Physical Therapy is excited to help you achieve your goals.

Sincerely,

Ryan Cook, PT, DPT

Patient Information

Last Name: _____First Name:_____ MI:_____
SSN: _____-_____-_____ Date of Birth: _____/_____/_____ Gender: _____
Address:_____ Apt: _____
City: _____State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Email (required): _____ Marital Status: _____
Primary Care Physician: _____

Employment Information

Employment Status: Full-time Part-Time Self-Employed Not Employed
Retired Student Active Duty
Employer Name: _____
Employer Address: _____
Work Phone: _____ Job Title: _____

Emergency Contact Information

Emergency Contact First and Last Name: _____
Phone: _____ Relationship: _____

Insurance Information

Have you verified your therapy benefits with your insurance? If not, we strongly encourage you.
Primary Insurance: _____Member ID #: _____
Policy Holder: _____ SSN: _____ DOB: _____
Relationship to Patient: _____ Policy Holder's Employer: _____

Secondary Insurance: _____Member ID #: _____
Policy Holder: _____ SSN: _____ DOB: _____
Relationship to Patient: _____ Policy Holder's Employer: _____

Responsible Party (must be parent or legal guardian if patient is a minor)

Last Name: _____ First Name: _____ MI: _____
SSN: _____ Date of Birth: _____ Gender: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Email: _____ Relationship to patient: _____

How did you hear about Action Physical Therapy?

Patient Name: _____

Medical History Form Please answer to the best of your ability.

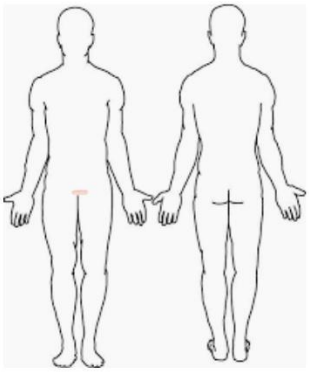
Date of Injury/Surgery: _____ **Cause of Injury:** _____

Was this related to either of the following? (Circle one if appropriate) **Work** **Motor Vehicle**

Have you ever had these symptoms before? YES / NO **Related Surgery?** YES / NO

Are you receiving Home Health Services? YES / NO

Indicate where you have pain/symptoms on the body chart with an X.



Rate your pain 0 – 10. (0= no pain, 10 = excruciating pain)

As of Now: _____ **Constant?** Yes or No

Worst: _____

Best: _____

Indicate the nature of your pain and symptoms Circle all that apply

Sharp Aching Shooting Dull Tingling Burning Numbness

Do you use tobacco products? YES / NO

Have you had physical therapy in the last 6 months? YES / NO

Do you have or have you had any of the following?

Y/N	Diabetes	Y/N	Allergies to Aspirin	Y/N	Are you pregnant
Y/N	Chest Pain/Angina	Y/N	Hot/Cold Intolerance	Y/N	Surgeries
Y/N	High Blood Pressure	Y/N	Asthma/breathing difficulty	Y/N	Headaches
Y/N	Heart Disease	Y/N	Other allergies	Y/N	Heart Attack
Y/N	Heart Palpitations	Y/N	Seizures	Y/N	Hernia
Y/N	Pacemaker	Y/N	Metal Implants	Y/N	Cancer
Y/N	Dizziness/Fainting	Y/N	Recent Fractures	Y/N	Stroke/CVA
Y/N	Kidney Problems	Y/N	Skin Abnormalities	Y/N	Urine Leakage
Y/N	Liver Problems	Y/N	Sexual Dysfunction	Y/N	Hypoglycemia
Y/N	Gallbladder Problems	Y/N	Special Diet Guidelines	Y/N	Infectious Disease
Y/N	Nausea/Vomiting	Y/N	Ringing in your ears	Y/N	Osteoporosis
Y/N	Rheumatoid Arthritis	Y/N	Bowel/Bladder Issues	Y/N	Other/Specify

If you answered Y to any of these, please specify: _____

_____

_____

Medication	Dosage	Frequency	Method of Administration

Any falls in the last year? _____ **If no falls, check here:** _____

When	What Happened	Any injuries?

Form Completed by: _____ Date: _____

Please print your name

ACTION PHYSICAL THERAPY

Patient Name:_____

Consent and Statement of Financial Responsibility

1. CONSENT FOR TREATMENT: I consent to and authorize my physical therapist to provide care and treatment prescribed by and/or considered necessary or advisable by my physician(s)/health care provider(s). I acknowledge that no guarantees have been made to me about the results of treatment.

2. **Appointment Attendance Agreement**: I understand the importance of attending therapy consistently and arriving promptly for my dedicated appointment time. I acknowledge that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I understand the importance of scheduling appointments in advance and acknowledge that appointment times given one week do not automatically follow through to subsequent weeks. I agree to provide at least a **24 HOUR** notice when I need to cancel or reschedule and an appointment that is cancelled with less than a **24 HOUR** notice or not showing up for appointment time will likely result in a cancel/no-show fee of **$30.**

   WORKERS COMPENSATION PATIENTS: We appreciate your full cooperation in attending all scheduled appointments. We are required to inform your Worker's Compensation Adjustor and/or Rehabilitation Manager of all missed, canceled or rescheduled appointments. It is also required all missed visits be rescheduled.

3. RESPONSIBILTIY FOR PAYMENT: All co-payments are due at time of service. I acknowledge that in consideration of the services provided to me by Action Physical Therapy, LLC, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide Action Physical Therapy, LLC with current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. My health insurance plan may decide that a portion of the charges and balance will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible.

4. ASSIGNMENT OF BENEFITS. I hereby assign to Action PT, LLC all my rights and claims for reimbursement under my insurance policy. I agree to provide information as needed to establish my eligibility for such benefits.

5. ACCESS TO/AND RELEASE OF HEALTH INFORMATION: I understand that Action PT, LLC documents with electronic forms and that such information will be used during my treatment for payment purposes and to support those who are caring for me. I authorize my clinician(s) and Action PT, LLC administrative staff to contact other healthcare professionals that may have information related to my prior and current health conditions and treatment. I acknowledge that I have received Action Physical Therapy, LLC Notice of Privacy Practice and that it outlines how my health information will be used and disclosed and how I may gain access to and control my health information.

6. HIPAA CONSENTS. In accordance with HIPAA regulations, I consent to the following individuals receiving verbal information regarding scheduled appointments, treatment and billing of account:

   Name/Relationship_____ Name/Relationship_____

I also authorize the release of appointment information left in a voice-mail, answering machine, text message or email and understand that there is a level of privacy risk associated with these forms of communication.

By signing my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

_____ _____ _____

Patient Name: _____

Appointment Reminder Consent Form

Complete this form and sign below to give permission for Action Physical Therapy, LLC to provide automatic appointment reminder service by email or cell phone text messages. By authorizing us to do so, you acknowledge understanding that there is some level of privacy risk associated with these forms of communication.

Select <u>One</u> Option Below

_____ Action Physical Therapy, LLC may send me email messages to confirm my upcoming appointments to _____.

_____ Action Physical Therapy, LLC may send cell phone text messages to confirm my upcoming appointments to _____. Normal text messages rates may apply.

Please understand that there may be times that these reminders are not functioning properly due to system or cell phone issues that we may not be aware of. While we are committed to resolving any issues that arise, these reminders cannot be guaranteed, and you should not solely rely on these reminders for your appointments. We ask that you, as the patient or patient's responsible party, still ultimately be responsible for your schedule. We at Action Physical Therapy, LLC are patient advocates and will do our best to work with you to provide great customer service.

Signature of Patient or Guardian: _____ Date: _____