ACCELERATED PHYSICAL THERAPY

ACCELERATING YOUR REHAB, ENHANCING YOUR LIFESTYLE.

PATIENT REGISTRATION

Motor Vehicle Accident

Area of Injury to be treated_____ Today's Date _____

Name _____
First MI Last

Address _____ _____
Street PO Box Apt #

Address _____
City State Zip

Home Phone _____-_____-_____ Work Phone_____-_____-_____ Cell Phone_____-_____-_____

SS# _____-_____-_____ Male or Female Marital Status M S D W

Guardian's SS# _____-_____-_____

Patient's Date of Birth _____ E-Mail : _____

Guardian's Date of Birth _____

How did you hear about us?_____

Emergency Contact Name & Number:_____

Employer Information Occupation_____

Employer _____

Address _____ _____
Street PO Box Apt #

Address _____
City State Zip

Physician Information

Primary Care Physician Name _____

Address _____
Street City ST Zip

Phone _____-_____-_____ Fax _____-_____-_____

Referring Physician Name _____

Address _____
Street City ST Zip

Phone _____-_____-_____ Fax _____-_____-_____

Have you had physical therapy for this accident before? ___ No ___ Yes If yes, when? _____

Motor Vehicle Claim Information

Claim Number_____ Insured Name _____

Have you completed and returned a Personal Injury Protection application to insurance company? _____

Insurance Company Name _____

Address_____
Street City State Zip

Phone _____-_____-_____ Claims Adjuster _____

ATTORNEY: Name & telephone number _____

Attorney address: _____

Health Insurance Information

Primary Insured Name _____ Insured Date of Birth _____

Relationship to insured _____ Insured Phone # _____

Insured Address if Different from Patient:

Address _____

Street City ST Zip

Health Insurance Co Name _____ Ins Phone #_____

Address_____

Street City State Zip

Group Number_____ ID Number_____

Contact Name _____

CONSENT TO TREATMENT

I hereby authorize the professional staff at ***Accelerated Physical Therapy, Inc*** to examine and treat me with physical therapy for the injury I have been referred here for or referred myself to.

_____ _____

Patient Signature Date

_____ _____

Patient Printed Name Staff Witness Signature

_____ _____

Parent or Guardian Signature (if under 18) Date

_____ _____

Parent or Guardian Printed Name Staff Witness Signature

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO HEALTH PROVIDER

Insurance Company/Companies Name(s) _____

I hereby instruct the above named insurance company/companies to pay by check made out to and mailed directly to: *Accelerated Physical Therapy, Inc* for professional or medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy. I understand that ***Accelerated Physical Therapy, Inc*** complies with HIPPA and will protect my Protected Health Information (PHI) and will use it as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed and full payment is received. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney for the purpose of securing payment under this policy of insurance or to any Medical Provider associated with my case to effectively treat me. The authorization is in effect until 90 days from the date the last bill is collected. **A $35 fee will be assessed for any returned checks. Monthly statements will be sent regarding your balance. If no response after the third statement, your account will be turned over to the Collection agency. A 35% collection fee will be added to any account which is turned over to the collection agency for non-payment. Legal fees may occur and sought for payment which will add a 50% collection fee to your balance.**

HIPPA REGULATIONS A photocopy of this Assignment shall be considered effective and valid as the original.
I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance under the HIPPA guidelines.

_____ _____

Patient Name (Printed) Date Patient Signature

_____ _____

Parent or Guardian (Printed) Relationship Parent or Guardian Signature

Witness _____ Date_____

MEDICAL HISTORY

Patient Name_____Age_____

Type of Injury/Condition_____

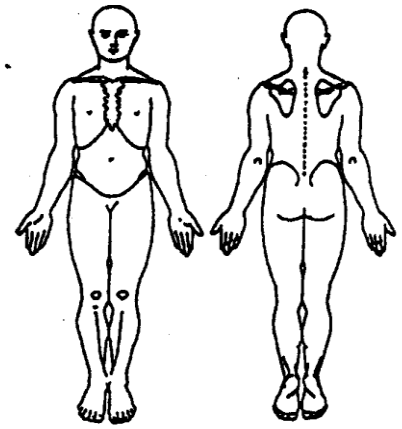
Onset/Injury Date_____

Type of Surgery & Date_____

Next Doctor's Appointment_____

Describe previous treatment for this condition_____

_____



Please mark the area(s) of concern

Have you received chiropractic treatment this year? Yes / No

Have you had any imaging performed:

□ X-Ray
□ MRI
□ CT Scan
□ Doppler
□ Ultrasound

Have you recently noted:

□ Weight Loss / Gain
□ Weakness
□ Pregnant / IUD
□ Pain at Night
□ Nausea / Vomiting
□ Fever / Chills / Sweats
□ Headaches
□ Cramps in Legs When Walking
□ Fatigue
□ Numbness / Tingling
□ Change in Vision / Hearing
□ Insomnia

Do you have now or have you ever had any of the following:

□ Surgeries
□ Sprains / Strains
□ Heart Problems
□ Circulation Problems / Clots
□ Easy Bruising / Bleeding
□ Rheumatoid Arthritis
□ Thyroid Disorder
□ Loss of Consciousness
□ Diabetes
□ Cancer
□ Asthma / Breathing Problems
□ Leg / Ankle Swelling
□ Fainting
□ Stroke/CVA
□ Fractures
□ Blood Pressure Problems
□ Motor Vehicle Accident
□ Lung Disease
□ Urinary Problems / Infections
□ Allergies / Skin Sensitivity
□ Seizure Disorder

□ Any previous injury that may affect current care _____

Explain and give approximate dates for any items indicated above _____

_____

_____

_____

What do you hope to get out of your treatment? _____

_____

What are your physical or fitness goals? _____

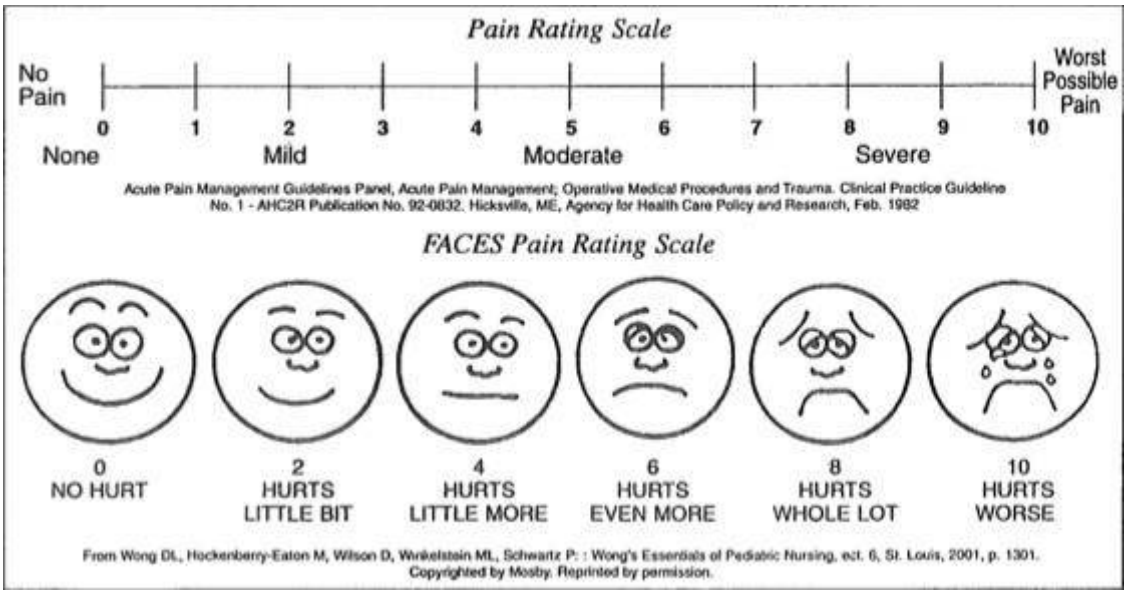
_____

_____ _____

Patient or Personal Representative Signature **Date**

PAIN AND MEDICATION QUESTIONNAIRE

PLEASE INDICATE THE LEVEL OF YOUR PAIN BY MARKING EITHER GRAPH BELOW



PLEASE LIST ALL MEDICATIONS (PRESCRIPTION,OVER THE COUNTER, HERBS, VITAMINS/MINERAL/ DIETARY SUPPLEMENTS)

MEDICATIONS	DOSAGE	HOW OFTEN TAKEN