PATIENT REGISTRATION FORM Date: _____

GENESIS PHYSICAL THERAPY

Patient Information

Last Name:	First Name:	MI:
Address:	City:	State/Zip:
Home Phone:	Cell Phone:	E-Mail:
Date of Birth: Age:	Drivers Lic. #:	SSN:
Employer:	Work Phone:	
Emp. Address:	City:	State/Zip:
Occupation:	Marital Status: ***S M D W***	Sex: ***M F***

Information for Financially Responsible Party if Not Patient (Patient is a Minor)

Last Name:	First Name:	MI:
Address:	City:	State/Zip:
Home Phone:	Cell Phone:	E-Mail:
Date of Birth:	Drivers Lic. #:	SSN:
Employer:	Work Phone:	
Emp. Address:	City:	State/Zip:
Occupation:	Marital Status: ***S M D W***	Sex: ***M F***

Insurance Subscribers Information ☐ Same as Patient Information

Last Name:	First Name:	MI:
Address:	City:	State/Zip:
Home Phone:	Cell Phone:	E-Mail:
Date of Birth:	Drivers Lic. #:	SSN:
Employer:	Work Phone:	
Emp. Address:	City:	State/Zip:
Occupation:		

Injury Information

Type of Injury: ***Work Sport Accident Illness*** Other:		
Condition:	Onset Date:	
Referring Doctor:		Phone:
Address:	City:	State/Zip:
Primary Doctor:		Phone:
Address:	City:	State/Zip:

PATIENT REGISTRATION FORM

Are your injuries accident related?	☐ Yes	☐ No
Are you currently employed?	☐ Yes	☐ No
Is your spouse or other family member employed?	☐ Yes	☐ No
Do you have a secondary insurance policy?	☐ Yes	☐ No
Have you ever served in the military?	☐ Yes	☐ No
Are you covered under any other health care plan?	☐ Yes	☐ No
Have you made any changes to your choice of Medicare options in the last open enrollment period?	☐ Yes	☐ No

Whom may we thank for referring you to us? _____

Emergency Contact Information

Last Name:	First Name:	Relation:
Address:	City:	State/Zip:

Authorization to Release Information: I hereby authorize Genesis Physical Therapy to furnish information only to insurance carriers, referring and family physicians and the California Department of Insurance concerning my condition and treatments rendered. I also authorize Genesis Physical Therapy to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information above and beyond what is necessary for the adjudication of a clean claim.

Assignment of Benefits: I hereby authorize that any insurance benefits for my treatment that are otherwise payable to me, to be paid directly to Genesis Physical Therapy. I also understand that should my insurance company send payment to me, I will forward the payment to Genesis Physical Therapy within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies.

I authorize Genesis Physical Therapy to initiate a complaint to the insurance commissioner for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

Additionally, I have received and or reviewed your "NOTICE OF PATIENT INFORMATION PRACTICES" which describes in detail how medical information about me is may be used and disclosed and how I can get access to this information.

_____ _____

Patient/Guarantor Date

Payment Information and Rehabilitation Contract

Welcome to Genesis Physical Therapy! We would like to take this opportunity to review our billing and payment procedures with you. We will happily discuss your proposed care and answer any questions you may have relating to your treatment and insurance coverage before we begin therapy. We are committed to providing you with the best possible care, and we are anxious to help you receive the maximum amount of benefit from any insurance coverage you have. However, your insurance is a contract between you and your insurance company. Since we are not a party to that contract, our relationship is with you. So, please take your time in reading through our billing policies below. If you have any questions about your financial obligations for your care, please let us know so that we may help you.

Private Insurance

1. You agree to be responsible for all of our charges, even if you have insurance. If you have any questions as to our fees for your care, please let us know before continuing your treatments.
2. Genesis Physical Therapy will bill your insurance company for you for all of your care one time only as a courtesy, and you agree to assign any insurance benefits for your treatment otherwise payable to you to come directly to Genesis Physical Therapy. Genesis Physical Therapy may require that repeated billings or reports required by your insurance carrier either be your responsibility, or may be done by Genesis Physical Therapy for a small fee. Genesis Physical Therapy will mail you an itemized statement to you monthly, even if we are billing your insurance for you. After your deductible is met, you understand that Genesis Physical Therapy will only wait up to 90 days after the date of service for your insurance company to pay directly any insurance benefits you may be due. After 90 days, you agree to pay your outstanding balance to Genesis Physical Therapy and then pursue the reimbursement from your insurance company thereafter. You agree to pay any portion of your bill not covered by your insurance upon receiving your statement each month.
3. You understand that Genesis Physical Therapy will not accept the responsibility for collecting your insurance claim, or negotiating a settlement for you, if a dispute arises between you and your insurance company. If such a dispute should arise, you agree to pay your outstanding balance to Genesis Physical Therapy and then pursue the reimbursement from your insurance company thereafter.
4. If your account becomes 90 days past due, and you have not made satisfactory arrangements with our business office, you agree to pay an administrative service charge of 1½% per month (APR 18%) on unpaid balances after 90 days.
5. If any legal action is taken by Genesis Physical Therapy to collect the balance due on your account, you agree to pay Genesis Physical Therapy's reasonable attorney's fees and costs.

Workers Compensation

We will obtain authorization to treat you from your employer's insurance carrier before we begin treatment. You are responsible for making and keeping your own appointments. Carriers will be notified of missed appointments. (see All Patients below). If you fail to make or keep scheduled appointments, your treatment will be discontinued.

Third Party Billing, Liens, and Legal Cases

Third party billing and liens are not accepted. Payment arrangements must be made with us before you can begin your treatment.

HMO Insurance

HMO Insurance is not accepted. Payment arrangements must be made with us before you can begin your treatment.

Medicare

1. Genesis Physical Therapy has been approved as an official Medicare provider. This means that we bill Medicare for you, we agree to Medicare rates, and Medicare will send your benefits directly to us. You agree to be responsible for any deductible, co-payment or other charges or items or services denied by Medicare.
2. If you have a supplemental insurance policy in addition to Medicare, we will also bill that carrier for you but not until after Medicare first sends us their portion of your benefits.
3. Medicare requires you to visit your referring doctor and to obtain a new prescription for your treatment every 30 days.

_____
Patient Initials

4. There are some items and services that are not Medicare benefits and Medicare will not pay for them. Medicare has also determined that rehabilitation is not covered for some conditions, even if prescribed by your doctor. When you receive an item or service this is not a Medicare benefit, you are responsible to pay us for it, personally or through any other insurance you may have. These items and services are described on a separate form titled "Notice of Exclusions from Medicare Benefits". If you have any question as to whether or not you want to receive these items or services, please ask us.
5. Medicare will generally pay for a certain number of visits per diagnosis before they begin reviewing your claims for medical necessity. These limits are sufficient to treat many routine conditions. If you reach the limits in the general guidelines published by Medicare and you, your therapist and your doctor all agree that it is necessary to continue treatment in order to complete your rehabilitation, at that time you will be required to sign Medicare's Advance Beneficiary Notice so that we can make special financial arrangements with you. While secondary insurance polices often pay the 20% co-payment not covered by Medicare, most supplemental insurance companies do not provide additional coverage beyond what Medicare deems medically necessary.
6. You understand that Genesis Physical Therapy will not accept the responsibility for collecting your secondary or supplemental insurance claim, or for negotiating a settlement for you, if a dispute arises between you and your secondary insurance company. Should such a dispute occur, you agree to pay your outstanding balance to Genesis Physical Therapy and then pursue reimbursement from your secondary insurance company thereafter.
7. If your account becomes 90 days past due, and you have not made satisfactory arrangements with our business office, you agree to pay an administrative service charge of 1½% per month (APR 18%) on unpaid balances after 90 days.
8. If any legal action is taken by Genesis Physical Therapy to collect the balance due on your account, you agree to pay Genesis Physical Therapy's reasonable attorney's fee and costs.

All Patients

1. We are happy to allow you to schedule your treatment time in advance if you wish. If you find that you are unable to keep an appointment, please notify us at least 24 hours in advance. We reserve the right to bill you if you fail to keep a pre-scheduled appointment, of if you cancel with less than 24 hours notice, except in cases of true emergency or illness. **Our customary fee of $45.00 will be billed to your account for a broken pre-scheduled appointment.** Since insurance companies and workers compensation do not pay for broken appointments, you agree that these charges will be solely your responsibility.
2. Medical Supplies. Some insurance carriers cover durable medical equipment, but many do not, nor do they pay for routine medical supplies. Therefore, we ask for payment for any medical supplies used as part of your treatment on the day they are issued. We will also ask you to pay for any special order items in advance.
3. All insurance co-payments and/or deductibles are due at the time of visit prior to treatment.
4. You are responsible to notify us immediately should any changes be made to your health insurance plan. Should you fail to do so, you agree to be responsible for all of our charges that are not covered by your insurance, even if you have insurance. If you have any questions as to our fees for your care, please let us know before continuing your treatments.
5. I also understand that should my insurance company send payment to me, I will forward the payment to Genesis Physical Therapy within 48 hours. I agree that if I fail to send the payment to Genesis Physical Therapy and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies.
6. I also understand that services rendered to me by are my financial responsibility and that the Genesis Physical Therapy will bill my insurance company, as a courtesy. I authorize my insurance company to pay my benefits directly to Genesis Physical Therapy and I understand that I will be fully responsible for any outstanding balance on my account.

I have read, understand and agree to the above payment procedures. I have received a copy of this contract, and agree that a photostatic or facsimile copy of this document is a valid as the original.

_____ _____

Patient/Guarantor Date

Health History Questionnaire

Welcome to Genesis Physical Therapy! Please take a few minutes to let us know why you are here as this will help us develop a treatment plan for you that will meet your individual needs. If you have any questions as to how to complete this form, please leave that section blank and ask the therapist for help.

PAIN SCALE

(1 thru 10) **0** = None **5** = Moderate **10** = Extreme

Current _____

Best _____

Worst _____

DESCRIPTION OF PAIN

- ☐ Burning
- ☐ Numbness
- ☐ Tingling
- ☐ Constant
- ☐ Sharp
- ☐ Worse at Night
- ☐ Dull / Achy
- ☐ Shooting
- ☐ Worse in Morning
- ☐ Intermittent
- ☐ Throbbing
- ☐ Other: _____

AGGRAVATING ISSUES

- ☐ Bending
- ☐ Sit ot Stand
- ☐ Walking
- ☐ Coughing
- ☐ Sneezing
- ☐ Swimming
- ☐ Laying Down
- ☐ Standing
- ☐ Stairs Down
- ☐ Sexual Intercourse
- ☐ Voiding
- ☐ Stairs Up
- ☐ Other: _____

TYPE OF INJURY

- ☐ Auto Accident
- ☐ Post Surgical
- ☐ Insidious
- ☐ Re-Injury
- ☐ New Injury
- ☐ Reoccurance of Pre Existing Injury
- ☐ No Apparent Injury
- ☐ Non - Specific
- ☐ Sports Injury
- ☐ Non-Work Related
- ☐ Work Related Injury
- ☐ Other: _____

GENERAL HEALTH STATUS

- ☐ Excellent
- ☐ Fair
- ☐ Good
- ☐ Poor
- ☐ Other: _____

HISTORY OF FALLS

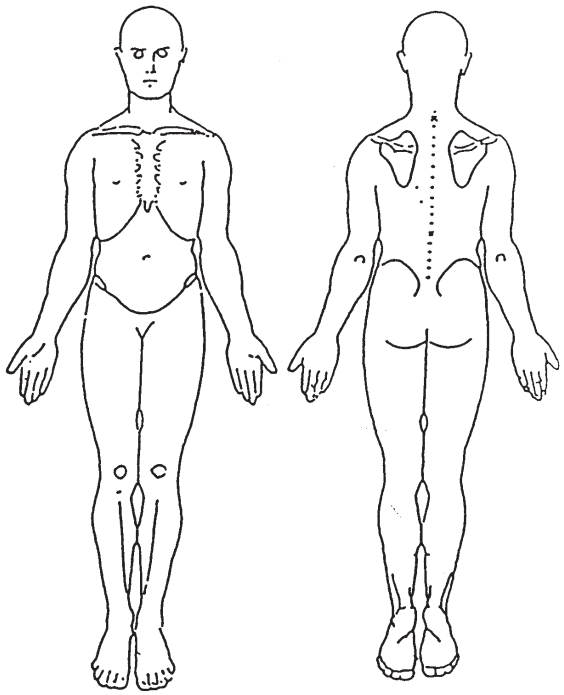
☐ No ☐ Yes

# of Falls in Last 3 months _____

# of Falls in Last 6 months _____

# of Falls in Last 12 months _____

On the diagram below, please shade in the area of your body that you have pain, numbness, and/or tingling. Describe pain (i.e. burning, aching, sharp, dull) next to the shaded area.



STATS

Age: _____

Height: _____

Weight: _____

CURRENT ACTIVITY LEVEL

- ☐ Sedentary
- ☐ Medium
- ☐ Light
- ☐ Heavy
- ☐ Other: _____

TREATMENTS RELATED TO CONDITION

- ☐ Acupunture
- ☐ Cardiologist
- ☐ Chiropractor
- ☐ Dentist
- ☐ Family Practitioner
- ☐ Internist
- ☐ Massage Therapist
- ☐ Neurologist
- ☐ Obstetritian / Gynecologist
- ☐ Occupational Therapist
- ☐ Orthopedist
- ☐ Osteopath
- ☐ Pediatrician
- ☐ Podiatrist
- ☐ Primary Care Physician
- ☐ Rheumatologist
- ☐ Other: _____

DIAGNOSTIC TESTS

- ☐ Angiogram
- ☐ Arthroscopy
- ☐ Biopsy
- ☐ Blood Tests
- ☐ Bone Scan
- ☐ Bronchoscopy
- ☐ CT Scan
- ☐ Doppler Ultrasound
- ☐ Echocardiogram
- ☐ EEG
- ☐ EKG
- ☐ EMG
- ☐ Mammogram
- ☐ MRI
- ☐ Myelogram
- ☐ NCV
- ☐ Pap Smear
- ☐ Pulmonary Function Test
- ☐ Spinal Tap
- ☐ Stool Tests
- ☐ Stress Test
- ☐ Urine Test
- ☐ X-Rays

Other: _____

CURRENT FUNTIONAL LIMITATIONS

- ☐ ADL's
- ☐ Ambulation / Mobility
- ☐ Bending
- ☐ Carrying
- ☐ Community Activities
- ☐ Lifting
- ☐ Pulling
- ☐ Pushing
- ☐ Stairs
- ☐ Reaching
- ☐ Self Care
- ☐ Sitting
- ☐ Sleeping
- ☐ Squatting
- ☐ Standing
- ☐ Recreational Activities
- ☐ Work
- ☐ Other: _____

MEDICAL / SURGICAL HISTORY

- ☐ Allergies
- ☐ Athritis
- ☐ Blood Disorders
- ☐ Broken Bones
- ☐ Cancer
- ☐ Cardio Vascular Disease
- ☐ Circulation / Vascular
- ☐ Diabetes
- ☐ *Denies PMH
- ☐ Depression
- ☐ Developmental Problems
- ☐ Head Injury
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Hypoglycemia
- ☐ Infectious Disease
- ☐ Kidney Problems
- ☐ Lung Problems
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Psyco - Social
- ☐ Repeated Infections
- ☐ Seizures / Epilepsy
- ☐ Skin Disease
- ☐ Stroke
- ☐ Surgeries
- ☐ Thyroid Problems
- ☐ Ulcers/Stomach Problems

Other: _____

MEDICAL SYMPTOMS THE PAST YEAR

- ☐ Bowel Problems
- ☐ Chest Pains
- ☐ Coordination Problems
- ☐ Cough
- ☐ Difficulty Sleeping
- ☐ Difficulty Swallowing
- ☐ Difficulty Walking
- ☐ Dizziness / Blackouts
- ☐ Fever / Chills / Sweats
- ☐ Headaches
- ☐ Hearing Problems
- ☐ Heart Palpitations
- ☐ Hoarseness
- ☐ Joint Pain or Swelling
- ☐ Loss of Appetite
- ☐ Loss of Balance
- ☐ Nausea / Vomiting
- ☐ Pain at Night
- ☐ Shortness of Breath
- ☐ Urinary Problems
- ☐ Vision Problems
- ☐ Weakness in Arms or Legs
- ☐ Weight Loss / Gain
- ☐ Pregnancy

Other: _____

CURRENT MEDICATION

- ☐ None
- ☐ Advil
- ☐ Aleve
- ☐ Antacids
- ☐ Antihistamines
- ☐ Aspirin
- ☐ Cortisone Injection
- ☐ Decongestants
- ☐ Dietary Supplements
- ☐ Epidural
- ☐ Herbal Supplements
- ☐ Ibuprofen
- ☐ Naproxen
- ☐ Over the Counter
- ☐ Prescription
- ☐ Tylenol
- ☐ Other: _____

SOCIAL / HEALTH HABITS

Smoking

☐ Does not currently smoke tobacco.

☐ Does curently smoke tobacco.

How many packs per day? _____

How many cigars/pipes per day? _____

☐ Smoked in the past. Year Quit: _____

Alcohol

How many days per week do you drink beer, wine or alcholic beverages, on average? _____

If one beer, one wine or one cocktail equals one drink, how many drinks do you have on an average day? _____

Exercise

Do you exercise beyond normal daily actvities and chores?

☐ Yes ☐ No

Describe the exercise:

_____

_____

On average how many days? _____

SOCIAL STATUS

☐ Single
☐ Married
☐ Divorced
☐ Widow
☐ Other: _____

☐ Lives with Family
☐ Lives with Caregiver
☐ Lives in Assisted Living Facility

OCCUPATIONAL STATUS

☐ Full-time - From Home
☐ Full-time - Outside of Home
☐ Homemaker
☐ Light Duty
☐ Not Working
☐ Other: _____

☐ Part-time - From Home
☐ Part-time - Outside of Home
☐ Retired
☐ Student
☐ Unemployed

WORK STATUS

Last Day of Work: _____

Return to Work: _____

Patient Goals: _____

PAST USE OF COMMUNITY SERVICES

☐ Day Services / Programs
☐ Home Health Services
☐ Home-Making Services
☐ Hospice
☐ Other: _____

☐ Meals on Wheels
☐ Mental Health Services
☐ Respiratory Therapy
☐ Therapies - PT, OT SLP

TYPE OF RESIDENCE

☐ 1-Story Home
☐ 2-Story Home
☐ Other: _____

☐ Apartment
☐ Condo

Work Related Problems. Complete this section if work is the area most affected by this current physical disability.

Job Title: _____

Hours scheduled to work per day: _____

Per week: _____

General job description: _____

Specific job tasks -
What kinds of specific physical tasks are you required to do?

_____

_____

_____

_____
Patient Name

_____
Patient Signature

_____
Date