Transformative Physical Therapy
FROM PAIN TO HEALING TO WELLNESS

Patient Registration

Name_____

Home phone_____**Cell phone**_____

Email_____

You will receive a text before your visit.

Date of Birth: _____**Age:**_____**Height:**_____**Weight:**_____

Home Address:_____

City/State Zipcode:_____

Emergency Contact (relationship): _____

Employer: _____

Business phone number_____

Insurance Provider: _____

Physicians (primary/specialist/phone numbers): _____

_____

What is your primary complaint: _____

_____

When did this occur: _____

Recent Medical Testing: _____

_____

Medications (attached sheet if preferred): _____

_____

_____

_____

Previous surgeries, including abdominal and musculoskeletal, include dates, if possible:

_____

_____

_____

Medical Conditions: Circle what applies

Osteoporosis/osteopenia	Car accident	Cancer/type:	Chemo/radiation
Heart Conditions	Pacemaker	High Blood Pressure	Stroke/TIA
Blood Clot/ Emboli	Dizziness/fainting ms	Respiratory Problems	Asthma
Tuberculosis	Irritable bowel syndrome	Constipation/diarrhea	Heartburn/reflux
Swallowing difficulty	Thyroid dysfunctions	Energy loss/fatigue	Weight loss/gain
Sleep dysfunctions	Bladder dysfunctions	Depression	Currently pregnant
Pelvic floor problems/IUD	Head trauma	Epilepsy/seizures	Psychological problems
Diabetes	Hearing dysfunctions	Vision dysfunction	Other

Goal(s) for therapy: _____

_____

Other information/concerns: _____

_____

_____

Authorization for Care/Informed Consent

I/we hereby authorize to receive care at Transformative Physical Therapy, LLC. I/we understand that receiving physical therapy or maintenance care may involve stress of musculoskeletal tissue that may cause soreness (like one might feel for a few days after starting a workout program such as running or lifting weights). Additional risks include, but are not limited to cardiovascular, muscle, ligament, joint or disc injury. Symptomatic aggravation of your current condition is also possible.

Furthermore, I/we understand that the provider may need to perform mobilization techniques, manipulation techniques, massage techniques, manual traction, distraction, electrical stimulation, taping, bracing, orthotic fitting, range of motions, muscle and movement facilitation, weight training and other movement modalities that may produce brief (several days) soreness and discomfort. It is my responsibility to communicate any difficulties that I/we are having during treatment to your doctor. It is also important to communicate any medical or activity changes that have occurred in my/our daily routine that may affect treatment decisions.

There are several benefits associated with testing. These include: confirmation of the present medical condition, qualifying physical abilities and comparing performance results with the physical demands of a specific job category or classification. There are also expected benefits associated with participation in a treatment program. These may include: increased flexibility and strength, decreased pain, improved cardiovascular endurance and coordination, and better circulation, all combining to improve function in activities of daily living.

Please acknowledge consent with full knowledge of the nature, risks and purpose of the evaluation and treatment program with your signature. X Initial _____

Payment Policy

The physical therapy services you receive are provided on a cash pay basis. Payment is expected by cash or credit card at the time of visit. Medicare patients may only be seen if they refuse, of their own initiative to allow submission of their bill. I will advise you in advance if you are able to receive care covered by Medicare at another location. **X Initial _____**

Attendance Policy

It is my pleasure to provide physical therapy services at Transformative Physical Therapy, LLC. In the event you are unable to keep a scheduled appointment or participate in your program, please notify me by text or phone, 1 day prior to your scheduled appointment. A cancellation fee may apply for less than 24 hrs notice. **X Intial _____**

Medicare's Mandatory Claims Processing Requirement Cash Pay Exception

Under rules promulgated in 2013 by the Department of Health and Human Services under the Health and Insurance Portability and Accountability Act of 1996 (HIPAA) an exception to Medicare's mandatory claims filing requirement has been created. In the 2013 guidance, HHS notes an existing proviso in Medicare law that if a Medicare patient refuses, of his/her own free will, to authorize the submission of a bill to Medicare, then the practice is not required to submit a claim to Medicare for the covered service and may accept an out-of-pocket payment, in full, from the patient.

Under HIPAA healthcare providers, Transformative Physical Therapy must allow a patient's request regarding restrictions on use or disclosure of his/her protected health information (PHI). This is only permissible if the patient, of his/her own initiation, requests to pay, in full (out of pocket) for a service or item.

While the law does not require the restriction requests to be in writing it does mandate that the provider document any restrictions to which it has agreed (or is required to agree). It is however, Transformative Physical Therapy's policy to obtain the requesting patient's attestation that the request was initiated by him/her.

My signature below is an attestation that I have read the above information presented as a result of my request to be a cash paying patient. I further attest that no one has provoked or encouraged the self-payment option I have elected. **X Initial_____**

Please sign and print your full name below:

Signature: _____Date: _____

Patient's Printed Name:_____Date:_____