HEALTH QUEST
PHYSICAL THERAPY & FITNESS CENTER, INC.
PATIENT REGISTRATION FORM

Patient's Name _____ Date _____

Mailing Address _____City _____ Zip _____

Home Phone _____ Cell Phone _____ Message Phone _____

Emergency Contact_____ Relationship_____ Ph._____

SSN#_____ Age _____ Sex: M F Date of Birth_____

Employer_____ Work Phone _____

Employer Address _____ Marital Status: M S D W

Referring Physician _____ Ph_____

WORKERS' COMP. CLAIMS

Comp. Ins. Carrier _____ Phone_____

Address_____

_____ Claim #_____

Employer _____ Date of Injury _____

Address_____ Phone_____

INSURANCE INFORMATION-PRIMARY

Insurance Type_____

Policy Holders Name_____ Date of Birth _____

Address _____ Home Phone _____

Employer _____ Work Phone _____

Policy No. _____ Group No. _____ Relationship to Patient _____

INSURANCE INFORMATION-SECONDARY

Insurance Type_____

Policy Holders Name_____ Date of Birth _____

Address _____ Home Phone _____

Employer _____ Work Phone _____

Policy No. _____ Group No. _____ Relationship to Patient _____

Health Quest
Physical Therapy & Fitness Center, Inc.

OUTPATIENT AGREEMENT

1. Attending therapy appointments on time maximizes your recovery and assists us with scheduling and staffing.

2. If you need to cancel an appointment, you must notify us at least 24 hours in advance to avoid the late cancellation fee.

3. If you fail to cancel 24 hours before your scheduled appointments, you will be **CHARGED $35 AUTOMATICALLY WITH NO EXCEPTIONS.**

4. If you are more than fifteen (15) minutes late, your appointment may be shortened or rescheduled at the therapist's discretion.

5. Missed appointments may affect workers compensation benefits. Physicians and insurance carriers will receive copies of progress and attendance records.

6. Children must be supervised at all times and are NOT allowed to play on the therapy equipment.

Please read and initial the following:

Many insurance companies require authorization for therapy services. Our office will verify insurance eligibility and benefits as a courtesy, however, IT IS ULTIMATELY YOUR RESPONSIBILITY TO KNOW WHAT YOUR HEALTH PLAN LIMITS ARE AND THAT YOUR PHYSICIAN'S OFFICE HAS COMPLETED THE REQUIRED AUTHORIZATIONS NECESSARY. Failure to obtain necessary authorizations may result in a reduction or rejection of benefits by your insurance company, which may result in you being billed directly.

_____ Initial

I have been informed, I fully understand and I agree to the Outpatient Agreement.

Patient Signature _____ Date _____

ASSIGNMENT AND RELEASE – ALL PATIENTS

I HEREBY AUTHORIZE the release of any and all information acquired in the course of my examination/treatment to my insurance company. I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE for all charges incurred during the course of my examination/treatment. I HEREBY AUTHORIZE and request the payment of medical benefits directly to **HEALTH QUEST PHYSICAL THERAPY & FITNESS CENTER, INC.** for services rendered to me by the physician/supplier. I authorize the use of this signature on all insurance submissions. A photocopy of this agreement is to be considered as valid as the original.

Signature_____ **Date signed** _____

FOR MEDICARE PATIENTS

I REQUEST that payment of authorized Medicare benefits be made to **HEALTH QUEST PHYSICAL THERAPY & FITNESS CENTER, INC.** for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I UNDERSTAND my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claims form is complete, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature_____ **Date signed**_____

FOR MEDICARE PATIENTS

Medicare patients are required to see their primary physician at least every 30 days. Your physical therapy prescription runs out after 30 days, regardless of the original prescription request. Medicare can deny payment if you do not receive a new physical therapy prescription from your physician every 30 days.

I understand that I must see my physician at least every 30 days in order to continue physical therapy.

Signature_____ **Date signed**_____

HIPAA POLICY ACKNOWLEDGEMENT

During your course of treatment at Health Quest Physical Therapy & Fitness Center, Inc., members of its staff may gather information about your medical history and your current health. During this process, Health Quest will remain HIPAA compliant. Your HIPAA rights are available for your viewing at any time. If you desire to read your complete HIPAA rights please ask at the front desk. Please note the posted HIPAA notice in the front lobby of Health Quest.

I acknowledge that Health Quest Physical Therapy & Fitness Center, Inc. is HIPAA compliant and will maintain confidentiality with all my protected health information.

Signature_____ **Date signed**_____

Past Medical History

Patient name: _____

Please check if you have been affected by any of the following medical conditions:

Heart Disease:

Yes	No		Yes	No	
☐	☐	Congestive Heart Failure (CHF)	☐	☐	Valvular Disease
☐	☐	High Blood Pressure	☐	☐	Stents
☐	☐	Heart Attack (Myocardial Infarction-MI)	☐	☐	Arrhythmia
☐	☐	Atherosclerotic Disease (CAD)	☐	☐	Coronary Artery Bypass Graft (CABG)
☐	☐	Angioplasty	☐	☐	Angina

Specify:_____
_____
_____

Lung Disease:

Yes	No		Yes	No	
☐	☐	Chronic Obstructive Pulmonary Disease (COPD)	☐	☐	Asthma
☐	☐	Emphysema	☐	☐	Recent Pneumonia

Specify:_____
_____
_____

Vascular Disease:

Yes	No		Yes	No	
☐	☐	Peripheral Arterial Disease	☐	☐	Stroke/TIA
☐	☐	Acquired Respiratory Distress Syndrome (ARDS)	☐	☐	Chronic Bronchitis
☐	☐	Diabetes	☐	☐	Hypertension
☐	☐	Taking Blood Pressure Meds			

Specify:_____
_____
_____

Patient name: _____

General Medical Conditions:

Yes	No		Yes	No	
□	□	Arthritis (rheumatoid/osteoarthritis)	□	□	Prior Surgery(s)
□	□	Allergies	□	□	Osteoporosis
□	□	Neurological Disease (such as MS or Parkinson's)	□	□	Anxiety or Panic Disorders
□	□	Headaches	□	□	Depression
□	□	Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)	□	□	Previous Accidents
□	□	Visual Impairment (such as cataracts, glaucoma, macular degeneration)	□	□	Kidney, Bladder, Prostate, or Urination Problems
□	□	Back Pain (neck pain, low back pain, degenerative disc disease, spinal stenosis)	□	□	Incontinence
□	□	Hepatitis/AIDS	□	□	Hearing Impairment (very hard of hearing, even with hearing aids)
			□	□	Sleep Dysfunction
			□	□	Prosthesis/Implants
			□	□	Cancer

Please List ALL Medications you are taking below or give a list you may already have to the office clerk for us to make a copy-

List Medications and any other disease or disorders (Not covered above):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Signature:_____ Date:_____