ProFlex PHYSICAL THERAPY

PATIENT REGISTRATION

(Please print clearly)

TODAY'S DATE: _____

LOCATION: _____

Patient Name: (Last) _____ (First)_____ (M.I.) _____
SS #: _____ Birth Date: _____ Marital Status: _____
Gender Assigned at Birth: ☐ Male ☐ Female Current Gender Identity: _____
Email: _____
Address:_____
City: _____ State:_____ Zipcode: _____
Home #: _____ Work #:_____ _____ Cellphone #: _____
Emergency Contact: _____ Relationship: _____
Emergency Contact Phone #: _____
Patient Employer: _____ Occupation: _____
Parent/Spouse Name: (Last)_____ (First)_____ (M.I.) _____
Parent/Spouse Employer: _____ Occupation: _____
Address: _____ City:_____ State:_____ Zipcode: _____
Home #: _____ Work #:_____ Cellphone #: _____
Date Of Illness/Injury/Accident: _____ Referring Doctor: _____ Phone #:_____
How did you hear about ProFlex PT? _____

Primary Insurance
Insurance Policy Name:_____
Address:_____
Phone #: _____
ID/Policy #: _____
Group #/Name: _____
Policyholder/Subscriber Name:_____
Policyholder/Subscriber SS #: _____
Policyholder/Subscriber DOB: _____

Secondary Insurance
Insurance Policy Name: _____
Address: _____
Phone #: _____
ID/Policy #: _____
Group #/Name: _____
Policyholder/Subscriber Name: _____
Policyholder/Subscriber SS #:_____
Policyholder/Subscriber DOB: _____

Workmen's Compensation
Date of Accident/Injury: _____
Insurance Carrier:_____
Address: _____
City, State, Zip: _____
Phone #:_____
Fax #: _____
Claim #: _____
Claim Adjuster: _____

Attorney Information
Attorney Name: _____
Address: _____
City, State, Zip: _____
Phone #:_____
Fax #:_____

Automobile Accident Information
Date Of Accident: _____ Auto Insurance Name: _____
Driver: Yes ☐ No ☐ Address: _____
Name of Insured/Policyholder: _____
Policy #: _____ Phone #: _____
Claim #: _____ Insurance Agent Name: _____

OVER

ASSIGNMENT OF MEDICAL BENEFITS, PRIVACY RIGHTS, AND CONSENT FOR TREATMENT

(Please print clearly)

THE UNDERSIGNED, hereby authorize ProFlex Physical Therapy and ITS AFFILIATES ("Provider") to render to Patient, physical therapy, occupational therapy, or other related services (collectively, "Therapy Services") that Provider or Patient's treating physician determines may be necessary or advisable. Patient agrees to cooperate with all reasonable requests by Provider in connection with Provider's rendition of Therapy Services.

THE UNDERSIGNED, hereby certify that all information provided to Provider by the undersigned or Patient, including any information in connection with applying for a payment under Title XVIII of the Social Security Act, is true and accurate in all respects.

THE UNDERSIGNED, hereby authorize Provider to disclose any information, furnished to Provider or obtained by provider in connection with Patient's treatment (including information concerning a related Medicare claim), to any physician, governmental agency (including the Social Security Administration or any of its intermediaries or carriers), insurance company or health care facility requesting such information.

THE UNDERSIGNED, hereby assign to Provider all Medicare benefits and Medicaid benefits to which Patient may be entitled for any Therapy Services rendered by Provider. The undersigned hereby authorize and direct Provider to apply and file for all such benefits on behalf of Patient. In the event Patient is covered by both Medicare and Medicaid, Patient's Medicare deductible and any applicable Medicare co-payment will be covered by Medicaid. The undersigned acknowledge that Provider has disclosed to the undersigned that Provider is a supplemental Medicaid provider and that Provider is paid directly by Medicaid. In addition, the undersigned approves contact with the appropriate family members for medical claims management process.

THE UNDERSIGNED, hereby assign to Provider all private medical insurance benefits or other benefits to which Patient may be entitled for any Therapy Services rendered by Provider. The undersigned hereby authorize and direct provider to apply and file for all such benefits on behalf of Patient.

THE UNDERSIGNED, authorizes ProFlex Physical Therapy to deposit checks received on Patient's account when made out to the patient or signed over by the patient when Insurance Company pays against services provided.

THE UNDERSIGNED, agrees that, he/she, shall be financially responsible for any portion of Provider's invoice that is not paid, except in the event of Medicare denial or Medicaid eligible recipients. The undersigned warrant and represent to Provider that Patient is not a member of, or covered by, a health maintenance organization or similar arrangement. The undersigned shall be liable to Provider for all services rendered by Provider in the event Patient is covered by a health maintenance organization or similar arrangement.

THE UNDERSIGNED and patient agree to execute any documents and perform any act that Provider may reasonably request. The undersigned warrant and represent that attached hereto are originals or certified copies of any applicable powers of attorney, health care surrogate forms or court orders appointing the undersigned as the legal guardian of the Patient.

THE UNDERSIGNED, agree that the provisions hereof shall continue in full force and effect until Provider has received written notice of termination signed by the undersigned; provided, however, that the provision of paragraphs 2, 4, 5, and 6 shall survive any such termination.

THE UNDERSIGNED, acknowledge that Provider has disclosed to the undersigned that no physician owns any interest in Provider.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize ProFlex Physical Therapy, to obtain my Protected Health Information including, but not limited to: history and physical exam, lab reports, progress notes, X-Ray reports, substance abuse (including alcohol/drug abuse), mental health (including psychotherapy notes), and HIV related information (including AIDS related testing).

I understand that this authorization will expire 365 days from the date I have signed this form and that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified, except to the extent action has already been taken in reliance upon it. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal Privacy regulations.

PRIVACY NOTICE

By my signature below, I acknowledge that I may request a copy of this practice's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law and understand my rights as a patient regarding my personal health information. To review the Notice of Privacy Policies, please visit https://proflexpt.com/patients/your-first-visit or request one from our front desk.

_____ _____

Patient Signature/Legal Representative/Insured Party Date

☐ *I understand that ProFlex PT does not and cannot guarantee the confidentiality of any forms submitted online. Although it is unlikely and despite ProFlex PT's security measures related to its own email system, there is a possibility that information sent from your publicly maintained email account or other email service provider may be intercepted.*

(Please print clearly)

Patient Name: _____ Date: _____

Date of Birth: _____ Height: _____ Weight: _____

Gender Assigned at Birth: ☐ Male ☐ Female Current Gender Identity: _____

Are you: ☐ Right-handed ☐ Left-handed

MEDICAL HISTORY

- ☐ Diabetes: Insulin/meds/diet
- ☐ Stroke
- ☐ Seizures
- ☐ Glaucoma
- ☐ Ear/nose/throat/mouth issues
- ☐ Asthma
- ☐ Thyroid: hypo or hyper
- ☐ Lung problems
- ☐ Heart problems
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Pacemaker
- ☐ Liver disease/hepatitis
- ☐ Anemia
- ☐ Bowel/intestinal problems
- ☐ Kidney disease/stones
- ☐ Hiatal hernia
- ☐ Skin disease
- ☐ Prostate disease
- ☐ Gynecologic disease
- ☐ Are you pregnant?
- ☐ Arthritis
- ☐ HIV/AIDS
- ☐ Stomach ulcers
- ☐ Mental health disorder
- ☐ Bleeding disorders
- ☐ Blood clots
- ☐ Blood transfusions
- ☐ Treatment of drug and/or alcohol problems
- ☐ History of cancer _____
- ☐ Peripheral neuropathy
- ☐ Other _____
- ☐ _____
- ☐ No known medical problems

List Any Drug Allergies: _____ Latex Sensitive: ☐ No ☐ Yes

_____

List All Previous Surgeries: _____ Month/Year _____

_____ _____

_____ _____

List Current Medications: Prescription _____ Non-prescription _____

_____ _____

_____ _____

SOCIAL HISTORY

Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

With whom do you live? _____ Does your home have stairs? ☐ No ☐ Yes, Where? _____

Current work status? ☐ Employed ☐ Homemaker ☐ Retired ☐ Unemployed ☐ Disabled

Occupation? _____

Current smoker? ☐ No ☐ Yes How many packs per day? ____ How many years? _____

Former smoker? ☐ No ☐ Yes How many packs per day? ____ How many years? _____

Alcohol use? ☐ Never/rarely ☐ Once/day ☐ Once/week ☐ Once/year

Hobbies or interests? _____

Regular exercise? ☐ Once/month ☐ Once/week ☐ 2-5 times/week ☐ Once/day

Type of exercise? _____

At the present time, would you say your health is excellent, very good, good, fair, or poor? _____

OVER

(Please print clearly)

Patient Name: _____

Are you currently seeing any other health care provider for this condition? ☐ No ☐ Yes,
Who? _____
Have you been discharged from the hospital, a skilled nursing facility, or home health agency in the past 30 days related to this condition? ☐ No ☐ Yes, Describe: _____

_____

When did your symptoms start? _____ Can you identify a cause for your symptoms? ☐ No ☐ Yes,
Describe: _____

_____

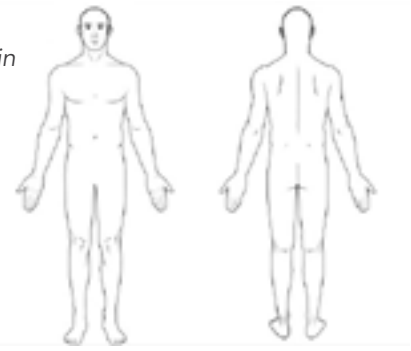
Have you ever had similar symptoms in the past? ☐ No ☐ Yes, When? _____

_____

Did you have any prior limitations in function or daily activities? ☐ No ☐ Yes
Were you able to perform all activities of daily living independently prior to onset? ☐ No ☐ Yes
Since the onset of your problem, have you had any of the following tests? ☐ No ☐ Yes
If yes, check all that apply:
☐ X-Ray ☐ Bone Scan ☐ Myelogram ☐ CT Scan ☐ MRI ☐ EMG ☐ Other

PAIN RATING: Indicate your level of pain by circling the appropriate number on the scale below.

☐ 0 — ☐ 1 — ☐ 2 — ☐ 3 — ☐ 4 — ☐ 5 — ☐ 6 — ☐ 7 — ☐ 8 — ☐ 9 — ☐ 10
Pain free *Worst Imaginable Pain*



Shade Areas of Pain

Do you have numbness or tingling? ☐ No ☐ Yes,
Where? _____
Have you had any changes in Bowel or Bladder? ☐ No ☐ Yes,
Explain: _____
Have you had any unexplained weight loss? ☐ No ☐ Yes, How much? _____ lbs.
Have you had any unexplained weight gain? ☐ No ☐ Yes, How much? _____ lbs.
Have you had a fall which resulted in an injury in the last year? ☐ No ☐ Yes
Have you fallen more than twice in the last year? ☐ No ☐ Yes
During the past month, have you often been bothered by feeling down, depressed, or hopeless? ☐ No ☐ Yes
During the past month, have you often been bothered by little interest or pleasure in doing things? ☐ No ☐ Yes
What are your goals for physical therapy? _____

_____

_____

Is there anything else you wish the therapist to know about your condition? _____

_____

_____

I have completed this form to the best of my ability and acknowledge that the information is correct.

_____ _____

Patient Signature Date

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