A Healing Hand
Physical Therapy

Registration Form

Patient Name: _____ **Date of Birth:** _____
Sex: M / F **Social Security Number:** _____ - _____ - _____
Address: Street _____
City: _____ State: _____ Zip: _____
Phone # Home: _____ Cell: _____
Work: _____
Employer: _____
Referring Physician: _____
Address: Street _____
City: _____ State: _____ Zip: _____
Primary Care Physician: _____
Address: Street _____
City: _____ State: _____ Zip: _____
Insurance Company: _____ Effective Date: _____
ID # _____ **Group #** _____
Policy Holder (if different than self): _____
Date of Birth: _____
Social Security Number: _____ - _____ - _____

Secondary Insurance: _____ Effective Date: _____
ID # _____ **Group #** _____
Policy Holder (if different than self): _____
Date of Birth: _____
Social Security Number: _____ - _____ - _____

Is your visit due to a job related injury or motor vehicle accident? Yes No
If yes please notify the receptionist immediately.

I authorize the release of any information necessary to process this bill to my insurance company, and request payment of benefits to Milva Catallozzi, PT, LLC. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature: _____ **Date:** _____

Signature of Parent/Guardian if patient under 18 years: _____
Date: _____

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Patient Name: _____ **Date:** _____

Medical History

1. Yes No Do you have high blood pressure? ( ) Controlled with medication?
2. Yes No Do you have heart problems? ( ) Controlled with medication?
3. Yes No Do you have a pacemaker?
4. Yes No Do you experience frequent heart palpitations?
5. Yes No Do you have angina(chest pain with exertion)?
6. Yes No Do you have a heart murmur?
7. Yes No Do you have an abnormal heart rate?
8. Yes No Do you have high cholesterol? ( ) Controlled with medication?
9. Yes No Do you have problems with shortness of breath?
10. Yes No Do you have asthma?
11. Yes No Do you have any chronic lung problems?
12. Yes No Do you have chronic heartburn, stomach or intestinal upset?
13. Yes No Do you have a history of ulcers?
14. Yes No Have you experienced significant recent weight loss or gain?
15. Yes No Do you have any bowel and/or bladder problems?
    (i.e. constipation, diarrhea, urgency to urinate)
16. Yes No Do you have diabetes? Are you Medication dependent? Yes No
17. Yes No Do you have low blood sugar? (Hypoglycemia)
18. Yes No Do you have thyroid problems? Type: _____
19. Yes No Do you have or have you had any cancer?
    Where? _____ When?_____
20. Yes No Do you have osteoporosis?
21. Yes No Do you have a history of neck and/or back pain?
22. Yes No Do you have migraine headaches?
23. Yes No Do you have a history of fractures?
    Where? _____ When? _____
24. Yes No Do you have metal implants?
    Where? _____
25. Yes No Do you have unusual joint pain and swelling unrelated to trauma?
26. Yes No Do you have osteoarthritis/rheumatoid arthritis?
27. Yes No Do you smoke? How much per day _____
28. Yes No Do you participate in a regular physical exercise program?
    How often? _____
29. Yes No Do you wear contact lenses or glasses?
30. Yes No Do you have impaired hearing?

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31. Yes No Do you have any chronic immune deficiency conditions? (i.e. Lupus, Fibromyalgia, etc) Other: _____
32. Yes No Are you currently being treated for any other condition not listed? (i.e. Depression, Anxiety, etc.) Other: _____
33. Yes No Do you have any allergies? List: _____
34. Yes No Are you pregnant or suspect pregnancy?
35. Yes No Do you have dysmenorrhea (abnormal menstrual cycles)?

Symptoms

1. Yes No Do you have "pins and needles" or a numbness sensation in your extremities?
2. Yes No Do your arms, hands, legs or feet swell as a result of your current condition?
3 . Yes No Do you have weakness in your arms or legs?
4. Yes No Do you have any coordination and/ or balance problems?
5. Yes No Do you have difficulty walking?
6. Yes No Do you experience dizziness/vertigo (feeling of spinning) with a change in position? (i.e. getting up from lying down)
7. Yes No Do you have episodes of blurred or double vision?
8. Yes No Have you experienced headaches as a result of your condition?
9. Yes No Do you have ringing in the ears?

Medications - list all medications, dosages and purpose for which you are taking it.

_____
_____
_____

Surgeries/Dates:

_____
_____
_____

Diagnostic Tests: check test for current problem only.

( ) X-rays ( ) CAT Scan ( ) MRI ( ) Bone Scan ( ) EMG ( ) Blood Chemistry
( ) Myelogram ( ) Bone Density ( ) Other (please list) _____

Have you seen anyone else for your current condition?

( ) Physician! PCP ( ) Chiropractor ( ) Podiatrist ( ) Orthopedic Surgeon
( ) Neurologist/Neurosurgeon ( ) Dentist ( ) Physical Therapist

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Chief Compliant! Current Condition: Please describe:

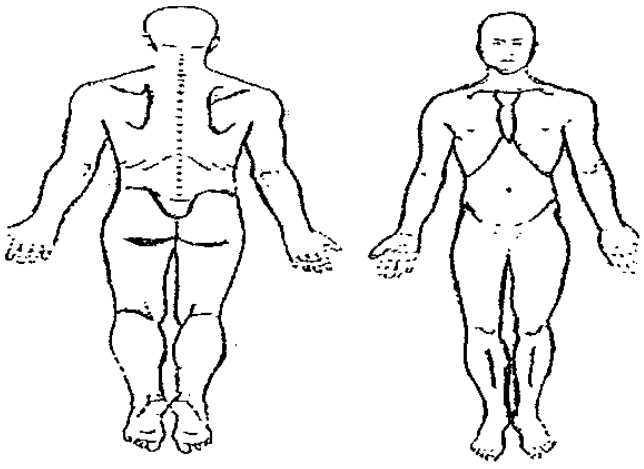
_____
_____
_____
_____

Please rate your pain using a O-1O scale where:

No Pain → 0 1 2 3 4 5 6 7 8 9 10 **← Worst Pain Imaginable**

Please mark where you are experiencing the pain:

_____
_____
_____
_____



I believe all the above information to be true and complete

Signature _____ Date: _____

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Office Policies

Physical Therapy services are reimbursed under the provisions of most health insurance policies. We will make every possible attempt to get the correct information regarding your particular benefits under your health insurance policy, but you as the subscriber are ultimately responsible for knowing the terms of your policy. If applicable, your insurance co-payments are payable on the day of evaluation or treatment. If you (the subscriber) should receive a check from your insurance company that is intended for this practice for services rendered, you should immediately remit this to our office for credit to your account. Failure to do so will result in our office billing you for the complete balance, and you will be responsible for payment of this amount in full.

Worker's compensation patients will be accepted, should your claim be denied by Worker's Compensation Court, you will be responsible for providing us with your third party insurance so that physical therapy services rendered to you can be submitted for payment. If you do not have a third party insurance we will make arrangements with you for payment.

Medicare patients are allowed a $2080.00 yearly combined physical and speech therapy benefit.

Please inform us if you have received any physical or speech therapy services this year. Medicare patients without supplemental insurance will be billed for their yearly deductible ($203.00), if not yet met, and 20% of the Medicare allowable fees.

Medicaid does not pay for outpatient physical therapy in a private practice.

We have a no show and cancellation policy: If you are unable to keep your scheduled appointment you must cancel 24 hours in advance or you will incur a $25.00 charge.
There is a voice mail service available 24 hours for your convenience. We understand emergencies happen but please make every effort to keep your scheduled appointment. Three no show or late cancellations will result in discharge from our facility. If you are going to be late for your appointment, please call to inform us of your expected arrival time. We may need to reschedule this appointment at the discretion of the therapist to ensure that your late arrival will not interfere with the treatment of the patient scheduled after you.

I have read and understand the policies of this office and agree to abide by them.

_____ _____

Signature of patient or guardian Date

I have read and understand your Notice of Privacy Practices.

_____ _____

Signature of patient or guardian Date