FYZICAL Therapy & Balance Centers

PATIENT REGISTRATION

Patient Full Name: _____ **Patient Account #** _____

Last Name **First Name** **Middle Initial**

Mailing Address

Street _____

City _____ State ____ Zip _____

Home Phone ( ) -

Cell Phone ( ) -

Work Phone ( ) -

E-mail _____

Billing Address (If different from mailing address)

Street _____

City _____ State ____ Zip _____

REQUIRED FOR BILLING:

Birth date ____ / ____ / ____ Age ____ Male ☐ Female ☐

Married ☐ Single ☐ Divorced ☐ Widowed ☐

Social Security Number: **Patient** _____ - _____ - _____

Social Security Number: **Insured** _____ - _____ - _____

Emergency Contact _____

Emergency Phone # ( ) - Relationship _____

MANDATORY IF YOUR CONDITION IS RELATED TO WORKER'S COMPENSATION OR AUTO CLAIMS

Employer _____

Occupation _____

Address _____

City _____ State ____ Zip _____

Is your condition related to:

Work ☐ Claim # _____

Auto ☐ Claim # _____

Auto Insurance _____

Claim Representative _____

Claim Representative Phone ( ) -

Referring Physician _____ Primary care physician _____

How would you like to receive reminders about your appointment? Text Message ☐ Phone Call ☐ Email ☐

Does your insurance require certification/authorization? Yes ☐ No ☐

Have you been seen at a CAPTA/FYZICAL Therapy clinic before? Yes ☐ No ☐

How did you hear about CAPTA/FYZICAL Therapy?

Returning Patient ☐ Family/Friend ☐ Web-Site ☐ Newspaper Ad ☐

Physician Recommend ☐ Facebook ☐ TV Ad ☐ Mailing ☐

For Office Use

Onset Date _____ Body Region _____

Referral Date _____ Diagnosis _____

Patient Account # _____

PATIENT REGISTRATION

Name: _____

How did your problem begin / injury occur?

_____
_____
_____
_____

Complaints regarding this injury/ problem:

_____
_____
_____
_____

Date of Injury: _____ **Date of Surgery:** _____

Related treatments and results:

_____
_____
_____

Medications (all):

_____
_____
_____
_____

Allergies: _____

Related Surgery: _____

Related Tests: X-Rays: ☐ CT Scan: ☐ MRI: ☐ EMG: ☐ Other _____

Other existing medical conditions: Pregnancy: ☐ Diabetes: ☐ High Blood Pressure: ☐ Epilepsy: ☐

Neurological Condition: ☐ Respiratory Disorder: ☐ Other: _____

Heart Problems (explain): _____

Cancer (explain): _____ Metal Implants (explain): _____

Employment: Full Time: ☐ Part Time: ☐ Student: ☐ Retired: ☐ N/A: ☐

Work Status: Off Work: ☐ Working with restrictions: ☐ Working without Restrictions: ☐

Occupation & Work Duties:

_____
_____

Patient Account # _____

PATIENT REGISTRATION

Name: _____

Mark ALL activities that you are having difficulty performing:

☐ Sitting	☐ Standing	☐ Walking	☐ Stairs / Curbs	☐ Lifting
☐ Reaching	☐ Writing	☐ Self Care	☐ Dressing	☐ Driving
☐ Yard Work	☐ Sleep	☐ Button/Tie/Zip	☐ Turning key	☐ Work
☐ Preparing meals	☐ Push/Pull	☐ Open a door	☐ Make bed	☐ Housekeeping

Other: (i.e. type of sport) _____

Handedness (mark one): ☐ Right Handed ☐ Left Handed ☐ Both

PAIN RATING SCALE:

Rate your Pain Level when at Rest: (mark one):

0 1 2 3 4 5 6 7 8 9 10

Mild Moderate Severe

Rate Your Pain Level with Activity: (mark one):

0 1 2 3 4 5 6 7 8 9 10

Mild Moderate Severe

Patient Account # _____

PATIENT REGISTRATION

Name: _____

Consent For Treatment I hereby give consent to Capitol Physical Therapy Associates, Inc. (D.B.A. FYZICAL Therapy Mid-Michigan) and its designated agents to provide evaluative and treatment services as necessary and reasonable for my care.

_____ _____

Signature (Or guardian if patient is a minor) Date

Authorization to Release Medical Information I hereby authorize Capitol Physical Therapy Associates, Inc. to release any information necessary to process this claim.

_____ _____

Signature (Or guardian if patient is a minor) Date

Billing Policy Capitol Physical Therapy Associates, Inc. as a service to our patients will submit your claim to your insurance company. Capitol Physical Therapy Associates, Inc participates with most insurance companies *(see below). **You are responsible for any copayments and/or a deductible according to your individual policy. Please check with your insurance company for the details of your policy since ultimately you are the person responsible for the cost of treatment.**

As payments are received by us from your insurance company, we will bill you for any copayments or deductible that may apply. Please make payment as you receive each bill A billing fee of $4.00 will be added for every duplicate statement sent for unpaid balances. If you know that paying your balance will be a hardship, please contact our billing office to work out payment arrangements. If it becomes evident that no effort is being made towards payment, your bill will be turned over to a collection agency.

I have read and UNDERSTAND the above and agree to accept responsibility for any balance on my account that are not payable by my insurance company. I give Capitol Physical Therapy Associates, Inc. permission to bill my insurance company on my behalf

_____ _____

Signature (Or guardian if patient is a minor) Date

***Not all insurance companies are willing to pay for rehabilitation services at Capitol Physical Therapy Associates, Inc.** Again please check with your insurance company regarding any stipulations.

Acknowledgement of Notice of Privacy Practices I have received and read the Notice of Privacy Practices of Capitol Physical Therapy Associates, Inc. You may request a copy.

_____ _____

Signature (Or guardian if patient is a minor) Date