

EXPRESS PATIENT REGISTRATION- SOAR PT

Personal Information

_____ Male Female
Last Name First Name Age Gender

Street Address City State Zip

Home Phone # Cell Phone # E-Mail Address (important)

Occupation Employer Work phone #

Current Work Status: Full Duty Restricted Unable Retired Disabled Student N/A or Unemployed

My condition is related to: Work Auto Accident Sports Surgery Injury Other Unknown

Emergency Contact Person Emergency contact #

k @

_____ Same or _____
Name of your referring physician Name of Family Physician

How did you hear about us? Physician Family/Friend Saw Location Internet other _____

Payment Options

- I have insurance (please complete Assignment of Benefits Form authorizing us to deal with them for you)
- I have a work related injury under worker's compensation I was in an automobile accident going thru auto insurance
- I will be "self-pay" and would like to take advantage of our "self-pay" discount (please ask to hear details on this)

***Accepted forms of payment include: Visa, Mastercard, Discover Card, Check, Cash

***I understand that I am responsible for my payment or portion of payment due according to my health insurance benefits at the time of service. I authorize SOAR Physical Therapy to evaluate me and initiate appropriate treatments.

Signature

Date

** (If Minor) I authorize SOAR PT to treat my child/dependent: _____

Important Company Policies for a Successful Relationship

We strive to provide you the best personalized care available. To make this possible we adhere to a set of very important guidelines. Please read them carefully, initial all the boxes, and indicate your agreement by signing at the bottom.

Initial
All
Boxes

Late Policy “10-minutes”

Being late by more than 10 minutes will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. We do not allow appointment overlap because this undeservedly compromises the care of another patient.

24-Hour Advance Notice Fee

If you wish to change or cancel an appointment we require a minimum **24-hour advance notice**. Anything less will result in a **\$10 fee** charged to your account. It costs us money to make appointments available to you. Whether you attend or not we still accrue the expenses (for staff wages, rent, etc.). We don't charge you the actual cost for that appointment but rather a mere **\$10 fee**. We do NOT make money with this charge; it's only to act as a deterrent from making last minute changes. Advance notice allows someone else (who needs it) time to reserve it in place of you. Please be courteous and responsible. Thank you.

Copays are due upon arrival

If you happen to forget your wallet or checkbook we may still be able to see you upon completion of an “Extension Request” form. This is a “promise-to-pay” form and carries a minimal fee that allows you to keep your appointment.

No-shows are bad

If you fail to show for an appointment without notice all future appointments will be removed and a **\$10 fee** assessed to your account. You may re-schedule appointments again on a “first come, first serve basis”.

Cell phones must be shut OFF or silent.

We realize emergencies may arise and therefore allow you to carry your cell phone during your session, however, please be courteous and set to silent mode or turn off. Thank you.

Children requiring supervision are NOT allowed to attend sessions with you.

Unless your facility offers child care services, you may not bring children who require supervision with you to your appointment. If your child does not require supervision and is capable of waiting for you quietly then you may bring them. If any disturbance is caused to other patients or staff members you may be asked to terminate your session early and attend to your child.

Financial Hardship

If you are experiencing financial difficulties and are unable to afford the cost of our services we have a “Financial Hardship Form” which may be filled-out. If you qualify for financial assistance according to the Federal guidelines, we may legally assist you by waiving or discounting your (patient responsibility) portions of the bill. Ask the front desk person for assistance.

Important Notice from the Federal Government:

“It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments . . . even if your doctor allows it. Unless you complete a “Financial Hardship” form and qualify for financial assistance under Federal Standards, you may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan even if your doctor allows it. You both may be charged for breaking the law. This includes services deemed as “professional courtesy” and “TWIP’s - Take what insurance pays”. Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, State Insurance Fraud Laws. Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128 A(a)(5) of the Health Insurance Portability and Accountability Act of 1996 [section 231(h) of HIPAA]. Exceptional cases do apply. Please see contact info for more information. Office of Inspector General, Department of Health and Human Services. Contact by phone: 202 619-1343, by fax: 202 260-8512, by email: paffairs@oig.hhs.gov, by mail: Office of Inspector General, Office of Public Affairs, Department of Health and Human Services, Room 5541 Cohen Building, 333 Independence Avenue, S.W., Washington, D.C. 20201, Joel Schaer, Office of Counsel to the Inspector General, 202 619-0089.”

We look forward to building a successful relationship with you that lasts a lifetime!

SOAR Physical Therapy Pre-Exam Questionnaire

In order to evaluate your condition fully, please be as accurate as possible. Thank you.

1. Have you had physical therapy before? Yes No **If Yes, Why?** _____

2. Where is your pain/problem? _____

3. Please describe your problem: _____

4. What caused your pain/or problem? Unknown or _____

5. Approximately when did it start? ____/____/20____

6. Is it getting worse, better, or staying the same? _____

7. Have you ever had this pain/problem before? Yes No **If so, what helped you manage or recover in the past?** _____

8. On the scale below circle your current, worst and best pain level in the past couple of days:

Current Pain

Mild *Moderate* *Severe*
0 ... 1 ... 2 ... 3 ... 4 ... 5 ... 6 ... 7 ... 8 ... 9 ... 10

WORST PAIN

Mild *Moderate* *Severe*
0 ... 1 ... 2 ... 3 ... 4 ... 5 ... 6 ... 7 ... 8 ... 9 ... 10

When I am feeling my best (least Pain)

Mild *Moderate* *Severe*
0 ... 1 ... 2 ... 3 ... 4 ... 5 ... 6 ... 7 ... 8 ... 9 ... 10

9. What helps your pain now? _____

10. What aggravates your pain now? _____

11. What activities are affected: _____

12. What are your goals in therapy or your recovery?

SOAR Physical Therapy Health History Form

Patient Name: _____

Have you ever been diagnosed as having any of the following conditions?

- | | |
|---|---|
| 1. Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Type: _____ | 19. Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Chronic urinary tract/bladder infection <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Multiple Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No | 21. Rheumatoid Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Bone or joint infection <input type="checkbox"/> Yes <input type="checkbox"/> No | 22. Degenerative Osteoarthritis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Other infections <input type="checkbox"/> Yes <input type="checkbox"/> No | 23. Gout <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Pelvic inflammatory Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | 24. Ankylosing Spondylitis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Heart Attack <input type="checkbox"/> Yes <input type="checkbox"/> No | 25. Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Heart Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | 26. Stomach/duodenal Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | 27. Epilepsy/Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Stroke (including mini-stroke/TIA) <input type="checkbox"/> Yes <input type="checkbox"/> No | 28. Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Deep Vein Thrombosis (DVT) <input type="checkbox"/> Yes <input type="checkbox"/> No | 29. Endometriosis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Anemia/low blood levels <input type="checkbox"/> Yes <input type="checkbox"/> No | 30. Urinary Incontinence <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No | 31. Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | 32. Neurological Disease/Condition <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 15. Chemical Dependency (ex. Alcoholism) <input type="checkbox"/> Yes <input type="checkbox"/> No | 33. Other Conditions _____ |
| 16. Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| 17. Depression <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |

Surgeries:

Type: _____ Date _____

Type: _____ Date _____

Type: _____ Date _____

Type: _____ Date: _____

Type: _____ Date: _____

Over the Counter (non-prescribed) Medications:

Advil, Motrin, Ibuprofen, Aleve Yes No

Aspirin Yes No

Tylenol/Acetaminphen Yes No

Decongestants/Antihistamines Yes No

Other: _____

Physician Prescribed Medications Being Taken:

Name of Medication (if known):

Anti-Inflammatories (Motrin, Ibuprofen, Relafen, Celebrex, Diclofenac, Naprosyn) Yes No _____

Muscle Relaxers (Flexeril, Soma, Skelaxin, Robaxin, Valium) Yes No _____

Pain Relievers (Darvocet, Percocet, Vicodin, Tylenol III, Oxycodone) Yes No _____

Blood Pressure Medication Yes No _____

Heart Medications Yes No _____

Insulin Yes No _____

Asthma Medication Yes No _____

Hormone Replacement Therapy Yes No _____

Antibiotics Yes No _____

Decongestants/Antihistamines Yes No _____

Seizure Medication Yes No _____

Thyroid Medication Yes No _____

Stomach or Acid reflux Yes No _____

Anti-Depressants Yes No _____



Assignment of Benefits to SOAR PHYSICAL THERAPY

Patient Name: _____ DOB _____

Insurance _____

ID # _____ Policy # _____

Insured Name: same as patient OR- _____

If Applicable (different): 1) Insured Date of Birth _____

2) Your relationship to the Insured: Parent Spouse Other: _____

I hereby instruct and direct my insurance company (outlined above) to pay by check or electronic funds to be made out and mailed to:

SOAR Physical Therapy
6768 Hickory Flat Highway, Suite 110
Canton, GA 30115
(770)704-8244

If my/this current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and **mail it to the above address** for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

(Check each box and sign at the bottom)

- A photocopy of this Assignment shall be considered as effective and valid as the original.
- I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- I authorize the use of this signature on all insurance submissions.
- I authorize SOAR Physical Therapy to deposit checks made in my name.
- I authorize SOAR Physical Therapy to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- I understand that I am financially responsible for all charges whether or not paid by insurance.

Dated this _____ day of _____, 20_____.

Signature of Policyholder (or claimant)

Witness