



Today's Date: _____

PATIENT REGISTRATION

Name: Last		First		MI
Address: Street		City	State	Zip Code
Home Phone		Cell Phone	Work Phone	
Birth date		Social Security #	Email Address	
Gender:	<input type="checkbox"/> Female	<input type="checkbox"/> Male	Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Employer		Occupation		
Emergency Contact Name		Phone #		
Referring Physician		Phone #		

INSURANCE INFORMATION

Primary Insurance	Insured's Name	Birth date of Insured
Policy Number/ID Number	Group Number	Relationship to Insured
Secondary Insurance	Insured's Name	Birth date of Insured
Policy Number/ID Number	Group Number	Relationship to Insured

MVA / WORKER'S COMP INSURANCE INFORMATION

<input type="checkbox"/> Work Comp	<input type="checkbox"/> MVA	Date of Accident: _____
Insurance Company Name	Address	Phone #
Claim Number/Policy #	Adjuster Name	Phone #

How did you hear about us?

<input type="checkbox"/> Family or Friend	<input type="checkbox"/> Physician Referral	<input type="checkbox"/> Insurance Website	<input type="checkbox"/> Internet
<input type="checkbox"/> I was a Former Patient	<input type="checkbox"/> Clinic Sign	<input type="checkbox"/> Yellow Page Advertisement	
Other: _____			

SIGNATURE

I, the undersigned, hereby request evaluation and treatment by Merit Rehab and consent to care and treatment as ordered by my physician(s). I authorize the release of information related to my rehabilitation to my physician(s). I hereby authorize my health insurance to make payment directly to Merit Rehab for any benefits I may receive. I realize that this may not represent the full payment for services rendered and that I will be responsible for the balance due within 90 days. I authorize the release of any information necessary to process my insurance claims and facilitate payment of my account by a third party.

Patient / Guarantor Signature: _____ Date: _____

Print Patient / Guarantor Name: _____

Relationship to patient: (please check one) Self Parent Legal guardian Power of Attorney

ID VERIFIED

PATIENT INTAKE QUESTIONNAIRE

Date: _____

Name: _____

Chief Complaint: _____

What are your symptoms? _____

When did your symptoms begin? _____

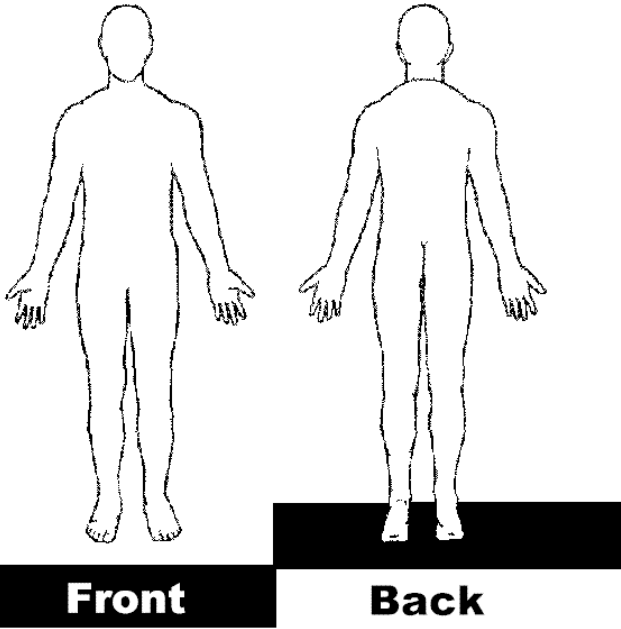
WHERE IS YOUR PAIN?

Please mark the body diagram to indicate the location of your pain:

Numbness =====

Sharp/Stabbing pain X X X X X

Burning ^^^^^^^^^^^^^



RATE YOUR PAIN

Please circle the level of your pain

1 2 3 4 5 6 7 8 9 10
(No pain) (Severe pain)

- Since onset, are your symptoms getting:
Better Worse Staying the same
- Are your symptoms
Constant Intermittent

If intermittent: How often do they occur? _____

How long do they last? _____

When do they get worse? _____

When are they best? _____

3. As the day progresses do your symptoms:
Increase Decrease Stay the same

4. Please list any activities you can't do now as a result of your injury/symptoms: _____

5. Have you seen any of the following during the past three months?

- | | |
|---|---|
| <input type="checkbox"/> Medical Doctor (MD) | <input type="checkbox"/> Physical Therapist (PT) |
| <input type="checkbox"/> Acupuncturist | <input type="checkbox"/> Osteopath (DO) |
| <input type="checkbox"/> Chiropractor (DC) | <input type="checkbox"/> Massage Therapist |
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Naturopathic Doctor (ND) |
| <input type="checkbox"/> Oriental Medicine Doctor | <input type="checkbox"/> Other _____ |

6. Have you had any of the following tests performed for this problem?

- | | | | |
|-------------------------------------|------------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> X-ray | <input type="checkbox"/> MRI | <input type="checkbox"/> CT Scan | <input type="checkbox"/> Bone Scan |
| <input type="checkbox"/> Arthrogram | <input type="checkbox"/> Lab Tests | <input type="checkbox"/> Other _____ | |

Results: _____

7. Please list any prescription medications you are currently taking (pain pills, injections and/or skin patches, etc.): _____

8. Do you exercise on a regular basis? Yes No
If yes, what type of exercise do you do? _____

PAST MEDICAL HISTORY

Please list any illness, medical & surgical history (ie: diabetes, high blood pressure, etc.) _____

What goals would you like to achieve from therapy?



Timberhill Physical Therapy

CONDITIONS OF REGISTRATION

Thank you for trusting Merit Rehab with your physical therapy needs. We take our commitment to you very seriously and look forward to working with you to enhance your health and well-being.

By signing the authorization for consent to treatment and Merit Rehab registration form, patient acknowledges and agrees to the following:

1. RELEASE OF INFORMATION: I authorize Merit Rehab to release my medical records to my health insurance for the purpose of billing and processing of my claim. I also agree to allow Merit Rehab to release my medical records and discuss health related and financially related issues to all health care providers, case managers, insurance representatives and lawyers that are involved in my case. A photocopy or a faxed copy of the release may be used in place of the original.

2. ASSIGNMENT OF INSURANCE BENEFITS: Merit Rehab has my permission to submit billings to my insurance company on my behalf and I authorize these payments to be made directly to Merit Rehab. I agree to pay all outstanding balances on my account within 30 days of receiving a balance due statement. I also agree to pay all insurance co-payments, deductibles and non-covered charges at the time of service. Should my account be referred to an attorney or collection agency for collection, I will pay actual attorney fees and collection expenses.

3. CANCELLATION AND MISSED APPOINTMENT POLICY: In the event that I am not able to make a scheduled appointment I agree to give at least **24 hours notice or (1 business day)** prior to my scheduled appointment, or be charged \$50.00. This policy enables Merit Rehab to schedule other clients who are in need of service in a prompt and timely manner.

Acknowledgement of Notice of Privacy Practices (To be retained by Medical Provider)

I understand that **Timberhill Physical Therapy** (referred to below as “the clinic”) will use and disclose **health information** about me in the course of providing physical therapy care to me.

I understand that my **health information** may include information both created and received by the clinic, may be in the form of written or electronic records, or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar health-related information.

I understand that the clinic is permitted to **use and disclose** my health information in order to:

- Make decision about and plan for my care and treatment;
- Refer to/or consult and coordinate with other health care providers in the course of my treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or other who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business function that support the clinic’s ability to provide me with appropriate care and arrange for payment.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request and that a copy or a summary of the most current version of the clinic’s Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that the Notice of Privacy Practices describes how I can exercise my right to ask that some or all of my health information not be used or disclosed, and I understand that the clinic is not required by law to agree to such requests.

By signing below, I agree that I have received or been offered a copy of the clinic’s Notice of Privacy Practices.

By: _____ Date: _____
(Patient)

- OR -

By: _____ Date: _____
(Patient representative)

Description of Representative’s Authority: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtain because:

Individual refused to sign

Communication barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please specify)