Patient Registration

*Last Name:	*First Name:	*Middle Name or Initial:

*Address:	*City	*State:	*Zip:

SSN:	*DOB: (mm/dd/yyyy)	*Age:	*Emergency Contact Name:	*Emergency Contact Relationship:	*Emergency Contact Phone Number:

*E-mail Address

Would you like to be added to our Email newsletter?

☐ Yes

☐ No

*Phone Number (If adding more than one, check your preferred)

☐ Cell:

☐ Home

☐ Work

☐ **I consent to receiving text message appointment reminders**

Physician Information

*Referring Physician

*Name:

Phone:

Fax:

*Location:

*Primary Care Physician:

*Name:

Phone:

Fax:

*Location:

How did you hear about us?

☐ Family/Friend ☐ Physician Referral ☐ Previous Patient ☐ Social Media/Yelp ☐ Internet search

☐ Workshop or event ☐ Insurance Company recommendation ☐ Work Comp/case manager

☐ Other (please list): _____

Consent for Treatment

I voluntarily consent to receive treatment at Goodlife Physical Therapy. I permit its employees and all other persons caring for me to treat me in ways they judge are necessary and proper in diagnosing and treating my physical condition. No guarantees have been made to me about the outcome of this care.

Patient/Guardian Signature _____ Date _____

Assignment of Benefits / Release of Information

I hereby assign all medical benefits to which I am entitled to Goodlife Physical Therapy in the event they file on my behalf. I hereby authorize said assignee to release all information, verbal and written, contained in my medical records, to secure payment.

I understand that I am financially responsible for all charges, whether or not paid by said insurance. Verification of benefits is not a guarantee of payment according to actual benefits quoted. In the event that my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount as well as all reasonable costs associated with the collection of this debt, including but not limited to collection of service fees, attorney's fees, and all court costs and additional legal fees.

Patient/Guardian Signature _____ Date _____

No Show / Cancellation Policy

We at Goodlife Physical Therapy are dedicated to assisting you meet your therapy goals. In order to do this, it is important that you attend all your scheduled appointments. We realize that there are times when unforeseen circumstances make it impossible to attend your scheduled appointment. If this happens, please give us as much notice as possible so we can reschedule your appointment and open that time slot for another patient.
Broken appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you.
In order to enforce this policy, you will be charged **$75.00 if you cancel an appointment less than 24 hours** before your scheduled appointment and **$150.00 if you do not show** for your appointment. If you are a worker's compensation patient, please be advised that your employer, physician, and case manager will be notified of each missed appointment. A copy of our full cancellation policy can be provided at your request.

Patient/Guardian Signature _____ **Date** _____

HIPAA Notice of Privacy Practices

I hereby acknowledge that I have read the Notice of Privacy Practices for Goodlife Physical Therapy. The therapist is required by applicable federal and state law to maintain the privacy of your protected health information. We are required to give you a notice about our policy practices and your rights concerning protected health information. We reserve the right to change our policy privacy practices. A copy of our Notice of Privacy Practices is available to you upon your request.

Patient/Guardian Signature _____ **Date** _____

Medicare Assignment

I certify that the information I gave in applying for payment of Medicare benefits is correct. I assign Medicare benefits payable to Goodlife Physical Therapy and I understand that I am responsible for any health deductibles and coinsurance amounts not covered by Medicare and/or my secondary insurance. (Please leave blank if not applicable to you.)

Patient/Guardian Signature _____ **Date** _____

FINANCIAL RESPONSIBILITY

I understand that insurance coverage is not guarantee of payment, and that I am ultimately responsible for services rendered at Goodlife Physical Therapy. I will honor Goodlife PT's payment policy as stated below:

- All co-payments and cash payment are due in full at the time of service
- Co-insurance and deductibles are the patient's responsibility and will be invoiced once the patient's insurance provider provides the Explanation of Benefits (EOB). Invoices will be due 30 days after receipt.
- I authorize payment of benefits directly to Goodlife Physical Therapy for services provided.
- Goodlife Physical Therapy has the right to consult a collection agency if payment is past due 90 days. If any portion of the account balance exceeds 60 days the patient will be charged $10 for each month the balance remains outstanding.
- I understand that I am financially responsible for payment of all services that are not paid by my insurance provider. Should my account be referred to collection, I will be responsible to pay costs of collections, including legal fees.
- I understand a fee of $25.00 will be assessed for any check returned unpaid.
- **I understand a fee of $20.00 will be charged for medical records upon my request due to the time and cost of producing the copies.**

Patient/Guardian Signature _____ **Date** _____

Patient Health Questionnaire - 2 (Check the box that applies)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				

WellRX		
Question (check yes (Y) or No (N) in the box to each of the following questions)	Y	N
In the past 2 months, did you or others you live with eat smaller meals or skip meals because you didn't have money for food?		
Are you homeless or worried that you might be in the future?		
Do you have trouble paying for your utilities (gas, electricity, phone)?		
Do you have trouble finding or paying for a ride?		
Do you need daycare, or better daycare, for your kids?		
Are you unemployed or without regular income?		
Do you need help finding a better job?		
Do you need help getting more education?		
Are you concerned about someone in your home using drugs or alcohol?		
Do you feel unsafe in your daily life?		
Is anyone in your home threatening or abusing you?		

EASI (Please complete if of the age of 60 or older, otherwise, please leave blank)		
Question (check yes (Y) or No (N) in the box to each of the following questions)	Y	N
Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?		
Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides or medical care, or from being with people you wanted to be with?		
Have you been upset because someone talked to you in a way that made you feel shamed or threatened?		
Has anyone tried to force you to sign papers or to use your money against your will?		
Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?		

Patient Medical History		
Reason for Visit	Location of Pain:	Date symptoms began:

Have you received treatment for your condition? □Yes □No
If so, please list: _____

Have you received any special tests related to this complaint? □ Yes □ No If YES, please select which one(s):
□ MRI □ CT Scan □ X-Ray □ Bone Scan Other:_____

In the past 2 years, have you undergone any surgical procedures or hospitalization? □ YES □ NO
If so, please describe:_____ Date of procedure/hospitalization: _____

Height: Weight:	List any medications you are currently taking, or please provide a copy:

Please indicate which of these words, if any, describe your pain. Select all that apply.
□ Aching □ Numb □ Shooting □ Tingling □ Burning □ Sharp □ Throbbing □ Other, explain

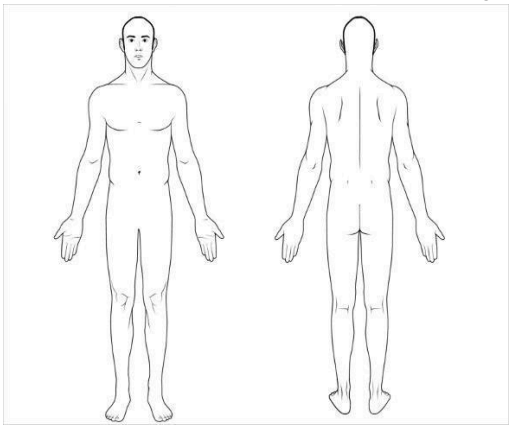
Rate your pain intensity on a scale of 0 – 10 (0=no pain)
Current: At Best: At Worst:

Name 3 activities impacted by your condition.
1.

2.

3.
On the body diagram below, please indicate where your current symptoms are located at the present time, or, describe your condition in your own words in the blank next to it.

X Pain **/////** Numbness **^^^^^** Tingling, Throbbing, Other



***Do you feel your weight or food choices play a role in your overall health? YES or NO**

***How would you rate your diet (pls. Circle): Good /Fair/ Poor**

***Are you Interested or would you like to be contacted about our nutrition services? YES or NO**

Have you been diagnosed with any of the following conditions?

□ Allergies	□ Depression	□ Kidney Stones
□ Anemia	□ Diabetes	□ Metal Implants
□ Angina/Chest Pain	□ Defibrillator	□ Multiple Sclerosis
□ Anxiety/Panic Attacks	□ Dizziness	□ Night Sweats
□ Arrhythmia	□ Emphysema	□ Osteoporosis
□ Arthritis	□ Fever for 2 or more weeks	□ Parkinson's Disease
□ Asthma	□ Fibromyalgia	□ Seizures
□ Blood Pressure	□ GERD	□ Stroke
□ Cancer	□ Headaches	□ Ulcers
□ Chronic Bronchitis	□ Heart Attack	□ Unexplained weight loss
□ Cirrhosis/Liver Disease	□ High Cholesterol	□ Other:
□ Chronic Coughing	□ Joint Replacement	

I, the undersigned, hereby certify that I have answered the questions listed above accurately, to the best of my knowledge

Patient/Guardian Signature: _____ **Date:** _____