Patient Name: _____ Account #: _____ Case: _____ Location: _____ IE Date: _____

FastBack PHYSICAL THERAPY
LET'S GET YOU BACK!

Patient Registration Form

PATIENT INFORMATION

Last Name	First	MI	Female Male	Birth Date	Age	Cell Phone#

Address	Apt#	City	State	Zip

SSN - Last 4 (Legal Guardian's if under 18):	Employer Name :	Employer # :	Marital Status

E-Mail	Home Phone#	Primary Care Physician	Phone#

Cell Phone Disclaimer: If you have included a Cell Phone number, you are giving our office or agent permission to call that phone.

Emergency Contact	Relationship	Cell Phone#

INSURANCE

Primary Insurance — **Claims Mailing Address (Listed on back of card)**

Policy#	Group#	Effective Date

Policy Holder Name	DOB	Relationship to Patient

Secondary Insurance — **Claims Mailing Address (Listed on back of card)**

Policy#	Group#	Effective Date

Policy Holder Name	DOB	Relationship to Patient

OTHER INSURANCE

Do you have work/auto CLAIM information ( )Y ( )N If Yes - select one:: Work Auto	Date of injury	Claim#

Insurance Name & Claims Mailing Address

Attorney/Adjuster Name — Attorney/Adjuster Phone#

UNIFORM OF ASSIGNMENT, RELEASE OF INFORMATION AND FINANCIAL DISCLOSURE:

All information provided herein is true and correct. I give permission to Fastback Physical Therapy to release/obtain information, verbal and written, contained in my medical record, and other related information to/from my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related person, as needed. I authorize direct payment to Fastback Physical Therapy for services provided. I acknowledge that I am responsible for all account totals and balances. I promise to notify Fastback Physical Therapy if at any time there is a change in my Insurance Policy(s) or Benefits. I expressly guarantee payment of the account/dependent named above, and agree to pay any charges left unpaid in whole or in part by the insurance company. **Cash Based Physical Therapy Packages & Sessions sales are final and no refunds will be issued.** I understand packages do not expire, and can only be redeemed at the original location of purchase and that any unused sessions are transferable to family/friends at the original location of purchase ***only***. I certify all information given is accurate. I certify that I have read and fully understand the above consents. **If the patient is a minor, their Legal Guardian must sign below.**

Patient/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

MEDICAL HISTORY

Patient Name: _____ **Acct#**: _____ **Case#:** _____ **Date:** _____

By taking the time to complete this form, you will be assisting us in planning your physical therapy or speech therapy treatment. Please be as thorough as possible. If there is information relevant to your treatment not outlined below, please bring it to the attention of your therapist. Thank you for your help.

Current Condition(s) / Chief Complaint(s)

Reason for coming to PHYSICAL / SPEECH Therapy: _____

When did the injury or problem start: _____ Was the onset GRADUAL or SUDDEN _____

PHYSICAL THERAPY ONLY SECTION

Location/description of pain: _____

_____

Is your current pain: Intermittent Constant Fluctuating

Do you have any of the following: Numbness Tingling

Have you had PT, chiropractic care, massage or acupuncture in the past 12 months? Yes No

If Yes: What were you treated for?_____

Where did you receive your care? _____

Please share any pertinent details about your care: _____

_____

***Prior* to the condition/injury**, please rate your functional status with self-care and home management activities? Excellent Good Fair Poor

Please rate your CURRENT functional status with self-care and home management activities: Excellent Good Fair Poor

Have you experienced any of the following (check all that apply)

Unexplained significant weakness upper or lower limbs		Changes in bowel or bladder function		Non-healing sores or wounds	
Fatigue		Fever/Sweats		Unexplained weight loss	
Pain worsened at night or not relieved by any position		Pain that is worse during rest vs. activity		Referred or radiating pain	

Family/Social History

Do you live alone?: Yes No If No, with whom do you live?: _____

Are you currently working? Yes No What is your occupation? _____

Pertinent Family History: _____

Living Environment

What type of home do you live in? 1-story 2-story Apartment Tri-level Other: _____

Any stairs to enter? Yes No How many? _____ Type of railing (L / R / None)?: _____

Patient Name: _____ **Acct#**: _____ **Case#:** _____

General Health Status

Height _____ Weight _____ Do you smoke? ☐ Yes ☐ No

How many days per week do you drink alcohol? ☐ Zero ☐ < 1 day ☐ 1-2 days ☐ 3-4 days ☐ 5-7 days/wk

What type(s) of exercise/activity do you normally participate in? _____

How often did you do this (if you weren't injured): ☐ 5+/wk ☐ 3-5x/wk ☐ 1-2x/wk ☐ 1-3x/month

Are you pregnant? ☐ Yes ☐ No If Yes, name of doctor: _____

Medical/Surgical History

Have you ever been diagnosed as having any of the following conditions? (Please check yes or no)

	YES	NO	LEAVE BLANK		YES	NO	LEAVE BLANK
Allergies				History of Falls			
Circulatory Problems				Hearing or Visual Impairment			
Asthma/Breathing Problems				Kidney Disease			
Attention Deficit Disorder				Osteoporosis			
Auto Accident				Seizures			
Brain Injury				Thyroid Problem			
Cancer				Vertigo			
Cognitive Issues				**SPEECH THERAPY ONLY SECTION**			
Arthritis				Respiratory Problems			
Heart Problems				Cleft Palate			
Depression				Developmental Delay			
Diabetes				Encephalitis			
Ear Infections				G-Tube			
Have a Pacemaker				Pneumonia			
Degenerative Illness				Chewing/Swallowing Problems			
High Blood Pressure				Voice Problems			

Please list any other injuries or diagnoses not indicated above: _____

_____

_____

Patient Name: _____ **Acct#**: _____ **Case#:** _____

Medical/Surgical History (continued)

Have you ever had surgery? Yes No

If Yes, please list what type and the date(s): _____

_____

What activities has your doctor instructed you to limit or avoid? _____

Medications

Are you currently taking any over-the-counter medications, vitamins, or herbal supplements? Yes No

If yes, please list which ones: _____

Have you had a flu shot recently? Yes No If yes, when? _____

Are you currently taking any of the following medications (please check box and indicate name of medication):

Corticosteroids		Name:	Antibiotics		Name:
Pain Relievers		Name:	Birth Control Pills		Name:
Insulin		Name:	Muscle Relaxers		Name:
Aspirin		Name:	Diuretics		Name:
Anti-Inflammatory		Name:	Tylenol/Acetaminophen		Name:
Decongestants		Name:	Heart Medications		Name:
Sleep-aid		Name:	Thyroid Medication		Name:

Other Clinical Tests

Have you had any of the following performed since your condition developed?

X Rays MRI Bone Scan CAT Scan Results: _____

Please list your current physicians and their specialty: _____

_____

What is your main goal in coming to Physical / Speech Therapy? _____

_____

Who can we speak with regarding your treatment and billing? _____ _____

Contact Name Phone Number

Consent For Care And Treatment & Acknowledgment of Receipt of Notice of Privacy Practices

I give consent for FastBack Physical Therapy to furnish medical care and treatment considered necessary and proper in treating my physical condition, or my speech/language/swallowing pathology. The undersigned Patient/Guardian acknowledges that he/she has been personally advised that copies of FastBack PT's Notice of Privacy Policies are posted at the point of care and that copies are available upon request.

Name: _____ **Signature:** _____ **Date:** _____

FASTBACK PHYSICAL THERAPY
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Overview
The law requires us to keep your protected health information ("PHI") private in accordance with this Notice of Privacy Practices ("Notice"), as long as this Notice remains in effect. We are also required to provide you with a paper copy of this Notice, which contains our privacy practices, our legal duties, and your rights concerning your PHI. From time to time, we may revise our privacy practices and the terms of our Notice at any time, as permitted or required by applicable law. Such revisions to our privacy practices and our Notice may be retroactive. Our Notice will be updated and made available to our patients prior to any significant revisions of our privacy practices and policies.

Organizations Covered by this Notice [Optional language for Organized Health Care Arrangements]
This Notice contains the privacy practices for [types of organizations] listed below, with the [types of facilities] sites they maintain for delivery of health care products and services. Each of these organizations participates in an organized health care management and may use and disclose your PHI among themselves as they shall deem appropriate for your treatment, payment or health care operations.

Our Privacy Practices
Use and Disclosure. We may use or disclose your PHI for treatment, payment, or health care operations. For your convenience, we have provided the following examples of such potential uses or disclosures:

> Treatment. Your PHI may be used by or disclosed to any physicians or other health care providers involved with the medical services provided to you.
>
> Payment. Your PHI may be used or disclosed in order to collect payment for the medical services provided to you.
>
> Health Care Operations. Your PHI may be used or disclosed as part of our internal health care operations. Such health care operations may include, among other things, quality of care audits of our staff and affiliates, conducting training programs, accreditation, certification, licensing, or credentialing activities. The use of sign-in sheets in which you sign in and out, as identified by HIPAA privacy regulations, does not constitute violation of your PHI.

Authorizations. We will not use or disclose your medical information for any reason except those described in this Notice, unless you provide us with a written authorization to do so. We may request such an authorization to use or disclose your PHI for any purpose, but you are not required to give us such authorization as a condition of your treatment. Any written authorization from you may be revoked by you in writing at any time, but such revocation will not affect any prior authorized uses or disclosures.

Patient Access. We will provide you with access to your PHI, as described below in the Individual Rights section of this Notice. With your permission, or in some emergencies, we may disclose your PHI to your family members, friends, or other people to aid in your treatment or the collection of payment. A disclosure of your PHI may also be made if we determine it is reasonably necessary or in your best interests for such purposes as allowing a person acting on your behalf to receive filled prescriptions, medical supplies, X rays, etc..

Facility Directories. [Optional Language for Inpatient facilities] Our facility directory may list the following information about you: (1) your name, (2) your location in our facility, (3) your general condition without reference to specific medical information, *e.g.,* stable, serious, fair, etc., and (4) your religious affiliation, if any. Our facility directory information may be disclosed to clergymen and, except for religious affiliation, to other people. You may restrict or prohibit the release of the above information.

Locating Responsible Parties. Your PHI may be disclosed in order to locate, identify or notify a family member, your personal representative, or other person responsible for your care. If we determine in our reasonable professional judgment that you are capable of doing so, you will be given the opportunity to consent to or to prohibit or restrict the extent or recipients of such disclosure. If we determine that you are unable to provide such consent, we will limit the PHI disclosed to the minimum necessary.

Continuing Care. Based upon your PHI, we may provide you with appointment reminders or information concerning health issues, benefits and services, or treatment alternatives that we believe may be of interest to you. Appointment reminders can include phone messages indicating applicable appointment information or appointment change requests.

Disasters. We may use or disclose your PHI to any public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Required by Law. We may use or disclose your medical information when we are required to do so by law. For example, your PHI may be released when required by privacy laws, workers' compensation or similar laws, public health laws, court or administrative orders, subpoenas, certain discovery requests, or other laws, regulations or legal processes. Under certain circumstances, we may make limited disclosures of PHI directly to law enforcement officials or correctional institutions regarding an inmate, lawful detainee, suspect, fugitive, material witness, missing person, or a victim or suspected victim of abuse, neglect, domestic violence or other crimes. We may disclose your PHI to the extent reasonably necessary to avert a serious threat to your health or safety of the health or safety of others. We may disclose your PHI when necessary to assist law enforcement officials to capture a third party who has admitted to a crime against you or who has escaped from lawful custody.

Deceased Persons. After your death, we may disclose your PHI to a coroner, medical examiner, funeral director, or organ procurement organization in limited circumstances.

Research. Your PHI may also be used or disclosed for research purposes only in those limited circumstances not requiring your written authorization, such as those which have been approved by an institutional review board that has established procedures for ensuring the privacy of your PHI.

Military and National Security. We may disclose to military authorities the medical information of Armed Forces personnel under certain circumstances. When required by law, we may disclose your PHI for intelligence, counterintelligence, and other national security activities.

Your Individual Rights

Access and Copies. In most cases, you have the right to review or to purchase copies of your PHI by requesting access or copies in writing to our Privacy Officer. Please contact our Privacy Officer regarding our copying fees.

Disclosure Accounting. You have the right to receive an accounting of the instances, if any, in which your PHI was disclosed for purposes other than those described in the following sections above: Use and Disclosures, Facility Directories, Patient Access, and Locating Responsible Parties. For each 12-month period, you have the right to receive one free copy of an accounting certain details surrounding such disclosures that occurred after April 13, 2003. If you request a disclosure accounting more than once in a 12-month period, we will charge you a reasonable, cost-based fee for each additional request. Please contact our Privacy Officer regarding these fees.

Additional Restrictions. You have the right to request that we place additional restrictions on our use or disclosure of your PHI, but we are not required to honor such a request. We will be bound by such restrictions only if we agree to do so in writing signed by our Privacy Officer.

Alternate Communications. You have the right to request that we communicate with you about your PHI by alternative means or in alternative locations. We will accommodate any reasonable request if it specifies in writing the alternative means or location and provides a satisfactory explanation of how future payments will be handled.

Amendments to PHI. You have the right to request that we amend your PHI. Any such request must be in writing and contain a detailed explanation for the requested amendment. Under certain circumstances, we may deny your request but will provide you a written explanation of the denial. You have the right to send us a statement of disagreement to which we may prepare a rebuttal, a copy of which will be provided to you at no cost. Please contact our Privacy Officer with any further questions about amending your medical record.

Complaints

If you believe we have violated your privacy rights, you may complain to us or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with us by notifying our Privacy Officer. We support your right to protect the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Us

FASTBACK PHYSICAL THERAPY

Phone: (262) 682-1842

www.FastbackPT.com