Symmetry Physical Therapy

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Patient Registration Form

First Name_____ MI___ Last Name_____ Title___

Date of Birth_____ Age:_____ Gender: Male____ Female_____

Mailing Address_____

_____

_____

Physical Address _____

_____

_____

Home Phone _____

Work Phone _____

Cell Phone _____ Best Time to Call _____

Marital Status

__Single
__Married
__Separated
__Divorced
__Widowed

Employment Status

__Full Time
__Part-Time
__Self Employed
__Active Duty
__Disabled
__Student
__Retired
__Unknown
__None

Email Address_____ Interpreter Required? __ Language_____

Patient Employer_____

Address _____

_____

Occupation_____

How did you hear about Symmetry?

__Physician __Previous patient
__Employer __Adjustor
__Case Manager _____Other

Was this injury the result of an accident? ___Work ___Auto ___Other ____N/A

Attorney Name_____ Phone_____

Address_____

_____

Emergency Contact _____ Phone_____

Address_____ Relationship_____

_____

Prescribing MD_____

Do you have a written prescription Yes ___No____

Are you the primary Insurance policy holder? Yes___ No____

**If not, please list primary insurance policy holder's name and date of birth*_____

Authorization to Release/Obtain Information

I hereby authorize the release of any and all information to my insurance company or other appropriate part, as required, pertaining to treatment rendered to me by Symmetry Physical Therapy. Further, I authorize Symmetry Physical Therapy to obtain needed information from my physician, employer, or insurance company.

Consent to Treatment and Financial Responsibility

I hereby understand and fully agree that (regardless of my insurance status) I am ultimately responsible for any balance owned to Symmetry Physical Therapy (Natalia Sikaczowski, DPT) for any medial services rendered to me, including any unfulfilled deductable amount and/or co-insurance on my insurance plan. I also understand that any balance not paid after 30 days will be charged finance fees as allowed per state (% subject to change). Furthermore, I also understand that should my account be transferred to a collections agency or attorney for collective action, I will be responsible for the principle amount and any collection fees, if any. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. I do hereby consent to such treatment by the authorized personnel of Symmetry Physical Therapy. This content is intended as a waiver of liability for such treatment except for negligence.

If a patient is a minor parent must sign this form and consent to treatment. Otherwise, services cannot be rendered by State Laws. I have read and understood all the above and I certify that this information is true and correct to the best of my knowledge. Also, I will notify Symmetry Physical Therapy if any of the above information changes during my treatment.

Notice of Information Practices

I acknowledge that I have been shown the posted notice of information practices by Symmetry Physical Therapy.

_____ _____

Signature of Patient or Parent/Guardian Date

Medical History Form

Area of Symptoms_____

Date of injury / onset: ____/_____/_____

Have you ever had physical therapy for theses symptoms before? ☐ Yes ☐ No

Have you had any x-rays/ MRI/ CT Scan_____

How many days since your current injury 0-30 ___ 31-90 ___ 90+_____

Have you had a related surgery? ☐ Yes ☐ No

Do you have, or have you had any of the following?

	Yes	No		Yes	No
Diabetes	☐	☐	Allergies to Aspirin	☐	☐
Chest / Angina	☐	☐	Allergies to Heat	☐	☐
High Blood Pressure	☐	☐	Allergies / Poor tolerance to Cold	☐	☐
Heart Disease	☐	☐	Other Allergies	☐	☐
Heart Attack	☐	☐	Hernia	☐	☐

Heat Palpitations	☐	☐	Seizures	☐	☐
Pacemaker	☐	☐	Metal Implants	☐	☐
Headaches	☐	☐	Dizziness / Fainting	☐	☐
Kidney Problems	☐	☐	Recent Fracture	☐	☐
Are you pregnant?	☐	☐	Surgeries	☐	☐
Cancer	☐	☐	Skin Abnormalities	☐	☐
Osteoporosis	☐	☐	Sexual Dysfunction	☐	☐
Bowel / Bladder Abnormalities	☐	☐	Nausea/ Vomiting	☐	☐
Urine Leakage	☐	☐	Ringing in your ears	☐	☐
Asthma / Breathing Difficulties	☐	☐	Rheumatoid Arthritis	☐	☐
Liver / Gallbladder Problems	☐	☐	Special Diet Guidelines	☐	☐
Smoking	☐	☐	Hypoglycemia	☐	☐

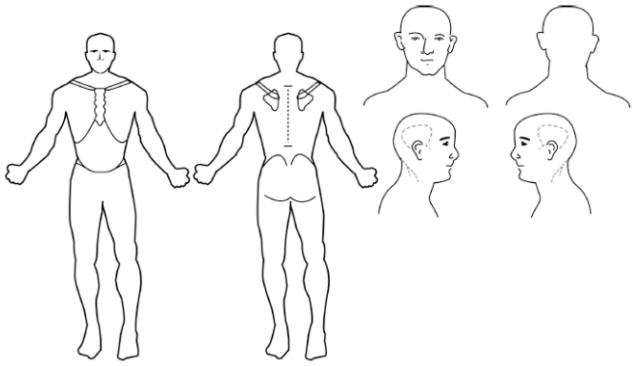
Please list any medications:_____

How would you rate your ability to perform routine daily activities?
0% __10% __ 20% __30% __40% __50% __60% __70% __80% __90% __100%__

How would you rate your ability to perform activities associated with your job?
0% __10% __ 20% __30% __40% __50% __60% __70% __80% __90% __100%__

How would you rate your current pain?
0 1 2 3 4 5 6 7 8 9 10
None Emergency Room

Please draw your pain on the body to the right:
/// Stabbing Pain
xx Burning
ooo Pins and needles
=== Numbness



_____ _____
Patient or Parent Guardian Signature Date

Payment Policies

To make the cost of your care as easy and manageable as possible, we offer several payment options. You can choose to pay by cash, check, or major credit card.

Co-Payments Must be paid at time of service. A $20 billing fee will be billed to you, in the event that we need to bill you for unpaid co-payments. You may leave your credit card on file to avoid this fee. All transactions will be charged on Mondays for the previous week's co-payments balance

Deductible Must be paid at time of your first visit, unless previous arrangements made with our billing department

Private Sessions Must be paid at time of service. For your records, a statement will be provided to you with the balance due and visit dates per your request.

All no-shows will be charged $85 Cancel without 24 hours notice $45

Please circle the method of payment that you are planning to use:
By Check: Please make checks payable to Symmetry Physical Therapy. There is a $30 charge for returned checks. ***Cash:*** Please ask for receipt if needed ***Credit Card:*** Will be charged on Monday for the previous weeks' balance

Credit Card on File information

Name on cc_____ Type: Visa ___ MC ___ Amex___ HSA___

CC number_____ Expiration Date_____

Cc cvv2/cvc2/cid (Amex only front of card) #_____

CC billing address zip code_____

Credit card information gets scanned into our billing department, stored in secure processing system and then ***blacked out****.*

I have read and understood all the above-mentioned payment policies at Symmetry Physical Therapy, I understand that if I leave my credit card on file, I can cancel this cc information though written authorization to Symmetry. If I elect to not leave a cc on file, I will pay my responsibility at the time of service. A finance change may be applied for due amounts not paid within 10 days and/or in event of declined credit card transaction. Also, if my account is sent to a collection agency or attorney for further collective action, I will be responsible for the fees, if any, as allowed per FL laws up to 35%.

My signature below constitutes as an authorization to charge my credit card as indicated and that I have read and understood Symmetry Physical Therapy's payment policies.

_____	_____	_____
Patient's Name (Print)	Patients Signature or Legal Guardian	Date

_____	_____	_____
Evaluating Therapist's Name	Evaluating Therapist's Signature	Date