Patient Registration Form – Commercial Insurance

Patient Name:		Preferred:	
Address, City, State, Zip:			
DOB:	Social Security #:		
Email Address:			
Home Phone:		Appointment Reminder Method	
Cell Phone:		☐ Home Phone	☐ Cell Phone/Text
Work Phone:		☐ Work Phone	☐ Email
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed		Partner's Name:	
Financial Responsibility: ☐ Self ☐ Other, Please List Parent/Legal Guardian Name:			
Address and Phone Number, if Different from Above:			
Social Security #:	DOB:	Relation:	
2nd Contact Info and Phone:		Relation:	
General Physician:	Referred By:		
Have you had Physical Therapy treatment since January of this year? ☐ Yes ☐ No		If yes, # of Visits:	
Have you had Chiropractic treatment since January of this year? ☐ Yes ☐ No		If yes, # of Visits:	
Have you had Home Healthcare in the last 30 days? ☐ Yes ☐ No If yes, Home Healthcare Provider:			

INSURANCE INFORMATION Please Note: A copy of your insurance card(s) will be kept on file. The patient is responsible to provide their most current insurance information.			
Primary Insurance:		Secondary Insurance:	
Group #:	Policy #:	Group #:	Policy #:
Insured Information:		Insured Information:	

Consent to Treat/Assignment of Benefits/Acknowledgements

I hereby authorize and consent to treatment/services for myself, or on behalf of the above-named patient performed by the staff at Mountain River Physical Therapy (MRPT) and/or as directed by my referring provider. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including risk or alternatives to the recommended treatment plan.

I assign payment for these services directly to MRPT. I authorize the filing of claims to my insurance plan and authorize MRPT to release necessary health information related to these services to process the claims. I certify that the information I have provided is accurate and complete.

In signing this form, I will promptly pay any required co-pay, coinsurance and/or deductible amounts. I accept that insurance plans may deny payments for what I believed were covered services, resulting in my responsibility for paying for these services.

I acknowledge that I have received the Notice of Privacy Practices, which describes the ways the practice may use or disclose my healthcare information. I understand that my healthcare information may be used for treatment, payment, healthcare operations and other permitted uses or disclosures as described in the Notice.

_____ _____

Signature of Patient/Guardian Date

_____

Print Name and Relationship to the Patient

Patient name:	DOB:

Authorization for Communication

By providing my above contact information and signing below, I consent and authorize MRPT and its related entities, agents, contractors, including but not limited to scheduling, billing, and other departments to use automated telephone dialing systems, SMS text messaging, and electronic mail to (1) provide messages (including prerecorded messages or text messages) to me about appointment reminders, patient surveys, my account, payment due dates, missed payments, information for or related to medical goods and/or therapy services provided, exchange information, changes to health care law, health care coverage, care follow-up, and other healthcare information or (2) provide messages (including pre-recorded messages) during a call or via text message that delivers a 'health care' message made by, or on behalf of, a 'covered entity' or its 'business associate' as those terms are defined in the HIPAA Privacy Rule, 45 CFR 160.103. I understand that providing a telephone number and/or email address is not a condition of receiving medical services.

I also understand that I may revoke my consent to contact at any time by directly contacting MRPT or using the opt-out method that will be identified in the applicable communication. I also understand that it is my responsibility to notify MRPT immediately of any change in telephone number or email address.

Patient/Guardian Signature: Date:

Release of Information

I hereby authorized MRPT to discuss my personal healthcare information regarding my treatment including diagnosis/prognosis and/or billing and payment for services rendered on my behalf to the person(s) listed below.

_____	_____	_____
Name (print)	Relationship	Phone number
_____	_____	_____
Name (print)	Relationship	Phone number
_____	_____	_____
Name (print)	Relationship	Phone number

Patient/Guardian Signature: Date:

Financial Policy

Payment for services is due at the time services are rendered

We will verify your benefits with your insurance carrier. However, this does not guarantee that they will cover the prescribed treatment. By signing below, you are acknowledging that you are responsible for deductibles, copays, coinsurance, and non-covered services not paid by the insurance carrier and understand that you are fully responsible for any balance due for services rendered.

Patient/Guardian Signature: Date:

Patient name:	**DOB:**

Cancellation/No Show Policy and Fee Acknowledgement

It is the policy of MRPT to monitor and manage appointment no-shows and late cancellations. Regular attendance at therapy sessions is crucial for you to recover fully and return to the activities you love. When an appointment is missed, it's a missed opportunity for progress in your recovery, and it impacts our ability to accommodate other patients who may need urgent care.

If you need to cancel or reschedule, please call the clinic.

Scheduled appointments must be cancelled or rescheduled at least 24 hours prior.

Failure to attend your appointment without 24-hour notice may result in a fee of $50 that will be charged directly to you as the patient (not insurance) for each instance of a missed appointment.

_____ _____

Signature of patient/authorized representative Date

_____ _____

Printed name Relationship to patient

PATIENT HEALTH QUESTIONNAIRE

Occupation: Height: Weight: Sex: ☐ Male ☐ Female

Leisure Activities/Hobbies:

Are you? ☐ Right-handed ☐ Left-handed

Where do you live? ☐ Private Home ☐ Apartment/Rented Room ☐ Assisted Living/Group Home ☐ Hospice ☐ Other:

With whom do you live? ☐ Alone ☐ Spouse Only ☐ Spouse and Others ☐ Child ☐ Other:

Does your home have? ☐ Stairs, No Railing ☐ Stairs, Railing ☐ Ramps ☐ Uneven Terrain
Please Explain:

How many times have you fallen in the past 12 months? Did it result in an injury? ☐ Yes ☐ No

During the past month have you been feeling down, depressed, or hopeless or bothered by having little interest or pleasure in doing things? ☐ Yes ☐ No

General Health Status: Please rate your health. ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list any known allergies (including medications, latex, etc.) below.

Patient name:	**DOB:**
Current Condition	
When did this problem(s) first begin/date of onset? If chronic, when did you seek medical treatment?	
Is your current condition related to recent surgery? ☐ Yes ☐ No If yes, specify date of surgery:	
Describe the problem(s).	
Explain how problem(s) occurred.	
Have you ever had this problem before? ☐ Yes ☐ No If yes, how many times?	
Are your symptoms worse in the: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Same All Day	
How are you taking care of the problem(s) now?	
My pain/problem is slowing getting: ☐ Worse ☐ Better ☐ Staying the Same	
My symptoms bother me: ☐ Constantly (100%) ☐ Most of the Time (75%) ☐ Occasionally (50%) ☐ Once in a While (25%)	
Do you have any numbness, tingling, or burning? ☐ Yes ☐ No If yes, please check one: ☐ Constantly ☐ Intermittently	
What functions could you perform before, that you now are unable to do?	
Please explain any specific treatment you have received for this problem, such as previous physical or occupational therapy, chiropractic visits, pain medications, etc.	
Have you received X-rays, MRI, CT scan, Bone scan for this problem? If so, please list the dates and results.	
Are you aware of any physical reason why you should not receive treatment? ☐ Yes ☐ No If yes, please tell us what it is:	
What are your goals for therapy?	

Surgery / Hospitalization, please include date and reason.	

Please list current medications (including prescription, over the counter, and herbal). You can also provide our office staff a list to copy.

Name	Dosage	Frequency	Please Indicate Route
			Oral Patch Topical Other
			Oral Patch Topical Other
			Oral Patch Topical Other
			Oral Patch Topical Other
			Oral Patch Topical Other

Patient name:		DOB:	
Are you currently experiencing any of the following?			
Nausea or Vomiting	☐ Yes ☐ No	Chest Pains (Angina)	☐ Yes ☐ No
Productive/Chronic Cough	☐ Yes ☐ No	Pain Wakes Me at Night	☐ Yes ☐ No
Difficulty Swallowing	☐ Yes ☐ No	Recent Fever, Chills, Sweats	☐ Yes ☐ No
Dizzy Spells	☐ Yes ☐ No	Difficulty Sleeping	☐ Yes ☐ No
Headaches	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Visual Problems	☐ Yes ☐ No	Heart Palpitations	☐ Yes ☐ No
Hearing Loss/Ringing in Ears	☐ Yes ☐ No	Loss of Appetite	☐ Yes ☐ No
Difficulty Walking	☐ Yes ☐ No	Incontinence	☐ Yes ☐ No
Unusual Weakness	☐ Yes ☐ No	Fatigue or Myalgia	☐ Yes ☐ No
Joint Pain or Swelling	☐ Yes ☐ No	Unexplained Weight Changes	☐ Yes ☐ No

Social History / Wellness	
Do you drink alcoholic beverages? ☐ Yes ☐ No	Do you use tobacco? ☐ Yes ☐ No
How often have you completed at least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your condition? ☐ At least 3 times per week ☐ 1-2 times per week ☐ Seldom or Never	

Have you been diagnosed with any of the following?			
Allergies	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	HIV	☐ Yes ☐ No
Hepatitis, If Yes, Type:	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Respiratory Problems	☐ Yes ☐ No	Kidney Disease/Problems	☐ Yes ☐ No
Auto Immune Disease If yes, Type:	☐ Yes ☐ No	Spinal Cord Stimulator	☐ Yes ☐ No
Blood Clots	☐ Yes ☐ No	Vision Problems	☐ Yes ☐ No
Bowel or Bladder Disorder	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Cancer, If yes, Site:	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Cardiac Conditions	☐ Yes ☐ No	Parkinson's	☐ Yes ☐ No
Cardiac Pacemaker	☐ Yes ☐ No	Peripheral Vascular Disease	☐ Yes ☐ No
Currently Pregnant	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Speech Problems	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Hearing Loss	☐ Yes ☐ No
Stroke/TIA	☐ Yes ☐ No	Fractures	☐ Yes ☐ No

I will advise the therapist if there is any change in my physical condition which will alter my response to any of the questions on this form.

Signature: _____ Date: _____