REGISTERED PHYSICAL THERAPISTS, INC.

Advanced, Personalized Care To Get You Back To Work And Play Fast

NEW PATIENT INFORMATION

Today's Date:_____

How did you hear about RPT?

☐ **Doctor:** _____ ☐ **Returning Patient** ☐ **Friend:** _____ ☐ **Insurance** ☐ **Facebook** ☐ **Internet** ☐ **Other:** _____

Full Patient Name _____ **Sex: M F S.S.#**_____-_____-_____ **Date of Birth** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone # _____ **Cell Phone #** _____ **Marital Status** _____

Email Address _____

Patient's/Guardian's Employer _____

Work Phone # _____ **May we contact you at work?** _____

Emergency Contact _____**Relationship** _____ **Phone#** _____

Responsible Party Name _____**Relationship** _____ **Phone #** _____

Responsible Party Address _____

SYMPTOM INFORMATION

Symptom First Noticed ____/_____/_____ **Body Part** _____ **How did it occur?** _____

Work Related? Y N Auto Accident? Y N State _____ **Date of Accident** _____

Did you need surgery? Y N Date of Surgery _____

Last seen by doctor_____ **Doctors Name and Phone #** _____

INSURANCE

Complete the spaces below with your primary health insurance unless your injury was due to an auto accident or is work related. If so, the insurance of the vehicle you were in or your employer's workers compensation information and your claim # is needed. In either of these cases enter your primary **health** insurance under secondary insurance.

Primary _____

ID # _____

Claim # _____

Subscriber's Name _____

Phone # _____

Date of Birth _____

SSN # _____

Relationship to Patient _____

Secondary _____

ID # _____

Claim # _____

Subscriber's Name _____

Phone # _____

Date of Birth _____

SSN # _____

Relationship to Patient _____

I agree that the information above is accurate to the best of my knowledge.

Responsible Party Signature _____ **Date** _____

MEDICAL & FINANCIAL INFORMATION - AUTHORIZATION AND RELEASE

The purpose of this Authorization and Release is for your protection. H.I.P.A.A. stands for Health Insurance Portability and Accountability Act. This Act was created for the sole purpose of protecting patient medical records and financial information. We request that you complete the information below and allow us to better protect your privacy of your medical information. We appreciate your attention to this matter. Please be specific when you indicate your choices. If you would like further information, please let us know.

I authorize the staff of Registered Physical Therapists Inc. to release any financial information to the following people and/or businesses.

Name of Spouse/Partner: _____
Parent or Guardian: _____
Other: _____
(e.g. Employer, Coach, Child)

I authorize the staff of Registered Physical Therapists Inc. to release any medical information to the following people and/or business.

Name of Spouse/Partner: _____
Parent or Guardian: _____
Other: _____
(e.g. Employer, Coach, Child)

☐ I choose not to release my information (medical and/or financial) to anyone at this time.

I agree to the terms and policies included within H.I.P.A.A. I understand that I have access to my own medical records until further notice or until written notification is received which requests nullification.

Patient Signature: _____ Date: _____
Parent or Guardian: _____Date: _____
(If patient is under the age of 18)

ASSIGNMENT AND RELEASE OF INFORMATION

I hereby authorize my insurance company to make payment directly to Registered Physical Therapists Inc. I further authorize Registered Physical Therapists Inc. to release information to my insurance company to process payment of my claims and any other company or person listed above.

Patient Signature: _____ Date: _____
Parent or Guardian: _____Date: _____
(If patient is under the age of 18)

COMMUNICATION

I authorize Registered Physical Therapists Inc. to send appointment reminders and/or newsletters.

Preferred Reminder Method:
□ Text Message - Cell Phone Number: _____
□ Voice Call – Phone Number: _____
□ Email – Email Address:_____

☐ I choose not to receive appointment reminder & newsletter communication from RPT Inc.

Patient Signature: _____ Date: _____
Parent or Guardian: _____Date: _____
(If patient is under the age of 18)

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RPT Electrode Policy
(Please read and sign below)

As part of your physical therapy treatment you will receive a procedure called electrical stimulation. This requires the use of electrodes (small sticky pads) to conduct the electrical current to the area being treated. For hygiene purposes we suggest that our patients purchase a set of electrodes that will be specifically for your personal use during your treatment. **The charge for this supply is $10.00**, which most insurance companies do not cover. We do not provide the service of billing your insurance for electrodes; therefore, we request the patient pay for the electrodes upon receipt.

You may opt to use the general electrodes that you will not be charged for; however, we suggest that each patient have their own set for sanitary reasons.

Please be aware that if you have not been treated for 3 months, we no longer have your electrodes on file. The electrodes lose their adhesive after that amount of time.

Yes, I would like to receive my own set of electrodes _____
Signature

No, I do not want my own electrodes _____
Signature