MILESTONE PHYSICAL THERAPY, INC.

PATIENT REGISTRATION

Full Name: _____ Birth Date: _____

Address_____City_____State: _____ Zip: _____

Phone 1: _____ H / C / W OK to leave voice message or text? ❑Yes ❑No

Phone 2: _____ H / C / W OK to leave voice message or text? ❑Yes ❑No

OK to leave message with (please indicate name and relationship) _____

E-mail address_____ OK to email? (MPT does not share email addresses) ❑ yes ❑no

Gender: ❑ Male ❑ Female Marital Status: ❑ Married ❑ Single ❑ Widowed ❑ Separated ❑ Divorced

Emergency Contact: _____ Phone: _____ Relationship: _____

Referred by Dr._____ Phone: _____ Fax: _____

Do you have a Primary Care Physician? ☐ Yes ☐No If so, Dr._____ Phone: _____

Patient's Employer: _____ Occupation: _____

Is this a Motor Vehicle Accident? ❑Yes ❑No Is this work related? ❑Yes ❑No

Date of Injury:_____ Body Part Involved: _____ right or left (please circle)

IF CHILD/DEPENDENT: Parent/Guardian/Bill Payee

Name: _____ Phone: _____ Relationship: _____

Address_____City_____State: _____ Zip: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Additional contact of Child/Dependent

Name: _____ Phone: _____ Relationship: _____

Insurance Information***: It is your responsibility to know the limitations and restrictions of your insurance plan***.

Name of Insurance Company: _____

ID#: _____Group#: _____Effective Date: _____

Policy Holder's Name: _____DOB: _____

Patient's Relationship to insured: ❑Self ❑Spouse ❑Child ❑Other:_____

Secondary Insurance Company (if any): _____ ID#_____

Have you had any Physical Therapy treatment this year? ❑Yes ❑No

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: (A copy of our Notice of Privacy Practices may be obtained on our website or in our office.) **Please check one box below.**

❑ I acknowledge receipt of the Notice of Privacy Practices.

❑ I understand a copy of the Notice of Privacy Practices is available to me. I have chosen to decline a copy at this time.

CONSENT TO TREAT: I hereby authorize you to evaluate and treat me (or my dependent) for the condition I am being seen for at Milestone Physical Therapy, Inc.

The above information is complete and accurate to the best of my knowledge and I understand and accept the information above. I acknowledge and understand that this information will be kept in my medical record. It is my responsibility to notify my healthcare provider should I change one or more of the telephone numbers and/or family members listed above. I understand that this information will be active until I revoke it in writing.

SIGNATURE: _____ DATE: _____

ACKNOWLEDGEMENT FORM FOR ESTIMATE OF BENEFITS/FINANCIAL POLICY

Benefits are not a guarantee of payment. We will obtain an estimate of benefits from your insurance company.

Patient Name: _____ DOB: _____/_____/_____
Primary Insurance: _____Member ID#_____Insurance Ph#: _____
Secondary Insurance: _____Member ID#_____Insurance Ph#: _____

PATIENTS SHOULD CHECK THEIR PHYSICAL THERAPY BENEFITS. It is recommended that you contact your insurance company and ask the questions below regarding your physical therapy benefits. This information will be obtained by our office also and reviewed with you at your first visit.

Ask for benefits for
"In Network Physical Therapy provided by a licensed Physical Therapist in an outpatient office"

Does deductible apply to PT? If yes, $_____ Amt. Met $ _____ Out of Pocket $_____ Amt. Met $_____
Is there a Copay? $_____ Coinsurance? _____%_ Number of visits allowed _____ Number used YTD_____
Is a prescription or referral required? _____ Representative spoke with_____ Date_____

PATIENT IS RESPONSIBLE FOR MEETING THEIR DEDUCTIBLE (if applicable) BEFORE INSURANCE PLAN WILL PAY. COPAYS ARE DUE AT THE TIME SERVICES ARE RENDERED.

Our office will be happy to bill your insurance company for you. However, we cannot accept responsibility for collecting from your insurance company, or for negotiating, a settlement or a disputed claim.
Patients who have Health Care Insurance should understand that charges for professional services are charged to the patient and not the insurance company. Payment for charges incurred, if denied by your insurance company, is ultimately the responsibility of the patient or the parent/guardian of patient if a minor.

FINANCIAL RESPONSIBILITY

I understand and agree that it is my responsibility to ask about any accumulated fees before and/or after services that have been rendered. I understand that if my insurance contract is terminated and/or cancelled during the time I am in Physical Therapy, it is my responsibility to bring Milestone Physical Therapy new proof of insurance. If I do not provide proof of insurance, I understand and agree that I am responsible to pay Milestone Physical Therapy 100% out of pocket for the services rendered. I understand that, regardless of insurance coverage, I am responsible for the balance of my account. All accounts are due and payable within 60 days. If I do not pay the balance in full within 60 days of the monthly billing date a finance charge will be added to the account of 1% per month, which is an annual percentage rate of 12%.

MEDICAL RECORDS RELEASE AND ASSIGNMENT OF BENEFIT PAYMENTS

I hereby authorize Milestone Physical Therapy to furnish medical records to insurance carriers concerning my physical therapy treatment. I hereby assign all payments from my insurance company to Milestone Physical Therapy for services rendered.

CANCELATION AND LATE POLICY

We attempt to accommodate all patient's schedules. Your physical therapy outcome is important to us. Missed or late arrivals to appointments effect your treatment and other patients who may need appointments. We realize emergencies arise but would appreciate immediate notice. Cancellations should be made at least 24 hours in advance**. If you are not able to reschedule the same day, a $50.00 fee may apply. Late arrivals may require the appointment to be rescheduled or canceled with a cancelation fee applied.**

I acknowledge receipt and agree with the above policies and responsibilities.

Patient Signature _____ Date_____

PATIENT HISTORY FORM

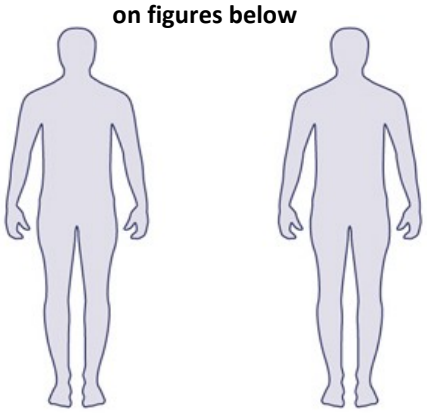
Patient Name: _____ **Sex:** M F **DOB**: _____Age:_____

Are you currently working? ❑Yes ❑No **Are you on Disability?** ❑Yes ❑No

Occupation: _____ **Physical demands**:_____

Injury/condition we are seeing you for: _____

Please mark problem area(s) on figures below



Rate your pain:

At rest: (no pain) 1 2 3 4 5 6 7 8 9 10 (agony)

With Activity: (no pain) 1 2 3 4 5 6 7 8 9 10 (agony)

Describe your pain (Circle all that apply):

Sharp	Tingling
Achiness	Dull
Numb	Constant
Off and On	Radiating (moves down the arm or leg)

FOR THIS INJURY/CONDITION:

When did this injury occur or the onset of symptoms begin: _____

How did this problem start? _____

_____

Any previous injury, if so describe? _____

What are your current limitations? _____

What eases your symptoms? _____

What aggravates your symptoms? _____

Have you had any X-rays, MRI's, CAT scans? _____

List previous treatment (IE: Injections, PT, Chiropractor). Did it help? _____

_____

What are your recovery goals (i.e. return to work, activities, etc.)?: _____

_____

List all relevant surgeries. Include mo/year:_____

Please list any current medications (prescribed and over the counter):

Drug Name: _____ Purpose: _____

Drug Name: _____ Purpose: _____

Drug Name: _____ Purpose: _____

Drug Name: _____ Purpose: _____

(USE BACK OF PAGE IF NEEDED)

MEDICAL HISTORY

Have you ever had any of the following?

High Blood Pressure	Heart Attack	Stroke	Asthma
Diabetes	Osteoarthritis	Rheumatoid Arthritis	Hepatitis
Cancer	Depression	Allergy to tape	HIV
Pacemaker	Seizures	Persistent swelling	Cardiac arrhythmias
Partial or total blindness	Hypersensitivity to heat or ice	Hearing impairment	Currently Pregnant

Notes or other relative medical history: _____

_____