FOUNDATION
Hand & Physical Therapy

Patient Registration/Authorization Form

PATIENT INFORMATION

Patient First: _____ M.I.: _____ Last: _____

SS: _____ Birth Date: _____ Age: _____ Sex: ☐ Male ☐ Female

Address: _____ Marital Status: ☐ S ☐ M ☐ D ☐ W

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email (optional): _____

Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Work Phone: _____

Spouse First: _____ M.I.: _____ Last: _____

Parent/Guardian First: _____ M.I.: _____ Last: _____

Relation to Patient (check one) ☐ Child ☐ Spouse ☐ Parent ☐ Other: _____

Parent/Guardian SS: _____ Birth Date: _____ Sex: ☐ Male ☐ Female

Parent/Guardian Employer: _____ Phone:____ _____

INSURANCE

Are you the primary policy holder? ☐ Yes ☐ No

Insurance Type: ☐ Auto ☐ Worker's Comp ☐ Medicare

☐ Medicaid ☐ Commercial ☐ Other: _____

Primary Insurance: _____

Policy #: _____

Group #: _____

Policy Holder Name: _____

Policy Holder DOB: _____

Relation to Patient: _____

Are you the secondary policy holder? ☐ Yes ☐ No

Insurance Type: ☐ Auto ☐ Worker's Comp ☐ Medicare

☐ Medicaid ☐ Commercial ☐ Other: _____

Secondary Insurance: _____

Policy #: _____

Group #: _____

Policy Holder Name: _____

Policy Holder DOB: _____

Relation to Patient: _____

INJURY

My condition is related to (check one): ☐ None ☐ Work ☐ Auto ☐ Sports ☐ School ☐ Other:_____

Date of injury/accident/onset: _____ Injury area: _____

Referring doctor: _____ Primary Doctor: _____

Diagnosis: _____

Have you had surgery related to this injury? ☐ Yes ☐ No If yes, date of surgery: _____

If your injury is related to work injury, do you have a case manager? ☐ Yes ☐ No

If yes, case manager Name: _____ Phone: _____

Work status: ☐ Full Duty ☐ Limited Duty ☐ Not working

If your injury is related to an accident, is an attorney involved in your case? ☐ Yes ☐ No

If yes, attorney name: _____ Phone: _____

-OVER-

Emergency Contact Name: _____

Phone: _____ Relation: _____

Please initial to the left of each statement in the squares below.

	Authorization for Treatment • I hereby give authorization for the performance of such rehabilitation procedures as permitted by *Kentucky* Statutes under the appropriate scope of practice are, in the judgment of my Therapist, deemed necessary.
	Authorization for Release of Information • I agree that Foundation Hand & Physical Therapy may provide information from my medical record to persons involved in my medical care. • I authorize the release of medical information necessary to obtain payment of any benefits available to me to Foundation Hand & Physical Therapy for services rendered. • I agree that Foundation Hand & Physical Therapy may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment. • I have read "Notice of Privacy Practices" mandated by HIPAA.
	Authorization for Release of Payment • I authorize that direct payment of any benefits available to me be released to Foundation Hand & Physical Therapy for services rendered.
	Patient Agreement • I agree to pay Foundation Hand & Physical Therapy charges for services rendered to me during my course of treatment. • I agree to pay those charges which may not be paid by my health insurance and are my responsibility per my insurance benefit. If I do not pay for charges that are my responsibility, I agree to Foundation Hand & Physical Therapy collections costs including attorney and court fees.
	Medicare, Medicaid, and Similar Benefits • I agree that the information given to Foundation Hand & Physical Therapy in applying for benefits under Medicare, Medicaid, and Maternal or Child Health services are complete and accurate. • I agree Foundation Hand & Physical Therapy may give Social Security Administration or its fiscal intermediary's information necessary to process claims.
	Workers Compensation • I agree that the information given to Foundation Hand & Physical Therapy in applying for benefits under Workers Compensation is complete and accurate. I agree that Foundation Hand & Physical Therapy may give intermediary's information necessary to process claims.
	Acknowledgement of Receipt of Privacy Policy • I acknowledge that I have received a copy of the Privacy Policies of Foundation Hand & Physical Therapy LLC and agree to the liability limitations explained there in.
	Authorization to Share Medical Information • I authorize Foundation Hand & Physical Therapy LLC to share information regarding my care with the individual(s) and to the degree that I have specified below. This release covers information concerning medical conditions and may include my medical history. I understand that this authorization may be revoked at any time (in writing). Authorization will automatically expire in the event that I am no longer a patient of Foundation Hand & Physical Therapy. Foundation Hand & Physical therapy is not responsible for any disclosure that may arise from the requested information. * I authorize _____(name/relationship) to: ☐ discuss medical condition/treatment ☐ receive appointment information ☐ discuss billing/collections on my behalf

Who may we thank for referring you to Foundation Hand & PT: _____

Patient Signature: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____
(if applicable)

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Hand & Physical Therapy

Patient Medical History Form

Patient First: _____ M.I.: _____ Last: _____

Date of Birth: _____ Referring Physician: _____ Sex: ☐ Male ☐ Female

Have you **RECENTLY** noted any of the following (check all that apply)?

☐ Changes in bowel/bladder function
☐ Nausea/vomiting
☐ Dizziness/lightheadedness
☐ Difficulty maintaining balance while walking
☐ Weight loss/gain
☐ Shortness of breath
☐ Headaches
☐ Changes in appetite
☐ Fever/chills/sweats
☐ Pain at night
☐ Weakness/fatigue
☐ Difficulty swallowing

Have you **EVER** been diagnosed with any of the following (check all that apply)?

☐ Cancer (type)_____
☐ Heart disease
☐ High blood pressure
☐ Asthma
☐ Pacemaker inserted
☐ Osteoporosis
☐ Chemical dependency (ie, alcoholism)
☐ Rheumatoid arthritis
☐ Stroke
☐ Depression
☐ Anemia
☐ Lung problems
☐ Thyroid problems
☐ Seizures
☐ Diabetes
☐ Multiple sclerosis
☐ Kidney/liver problems
☐ Stomach ulcers
☐ Epilepsy
☐ Parkinson's disease
☐ Other: _____

For women, are you currently pregnant or think you might be pregnant? ☐ Yes ☐ No

During the past month, have you been feeling down, depressed or hopeless? ☐ Yes ☐ No

What is your height? _____ Feet _____ Inches

What is your weight? _____

Do you use tobacco products? ☐ Yes ☐ No

Is your injury related to a fall? ☐ Yes ☐ No
If yes, how many falls have you had in the last year? _____

Please list current medications, include name, dosage, frequency and route: _____
_____
_____

Please list any allergies: _____
_____ Are you latex sensitive? ☐ Yes ☐ No

Please list any surgeries and date of surgery: _____
_____
_____

Pain at **LOWEST level:.** Rate lowest pain level in last 24 hour

Lowest Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

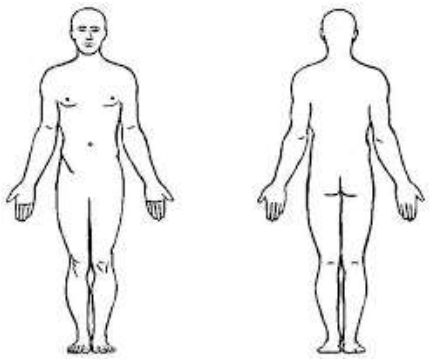
Pain **CURRENTLY:** Rate pain level at this time.

Lowest Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

Pain at **WORST:** Rate highest pain level in past 24 hours.

Lowest Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

Body Chart:
Please mark location of your pain and type of pain on the chart



Key: **X** sharp, stabbing pain
O dull achy pain
…… Numb/tingling
///// Throbbing
+++++ Burning

What is your goal for therapy at this time? _____

Patient Signature: _____ Date: _____

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Therapy Compliance

Effective therapy requires consistency in treatment. The plan of are determined by your therapist and/or physician is specifically designed for you and your condition. Compliance with this plan of care is for your benefit and is essential for optimal recovery. Ideally, all patients will be discharged when their course of treatment has been completed and their highest level of function has been restored. However, excessive no shows and cancellations can significantly limit your level of recovery and occupies appointment times that could be used for other patients. **Administrative discharges will occur of if any patient misses three (3) consecutive therapy appointments or five (5) appointment totals.** In order to resume treatment, you must see your physician, case manager (if applicable), and you regarding the administrative discharge from therapy secondary to noncompliance with your plan of care.

I have read and understand the therapy compliance policy.

Patient Signature: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____
(if applicable)