ENCORE PHYSICAL THERAPY

New Patient Registration Packet

Patient Demographics

Past Patient: ☐ YES ☐ NO	Today's Date	ID/DL verified ☐ YES ☐ NO
First Name	Middle Name	Last Name
Gender ☐ M ☐ F ☐ Other	Date of Birth ___/___/_______	SSN: _______-_______-___________
Address:	City and State	Zipcode
Phone Number:	Email Address:	

Emergency Contact

Contact Name	Phone #	Relation to Patient

Referring Physician Information

Name of Referring Physician	Physician Office/ Tel number#

Medicare Only - Additional Questions

If Medicare, are you currently Using any Home Health Services ☐YES ☐NO

If Yes, Please give the name of Home Health Agency ____

If Yes, what type of home health services are you receiving ? ______________________________________

Last Date of Service __________________________

If Medicare, have you received PT, OT, or Speech services Since the first of the Year ? YES ☐ NO ☐

If yes, Do you know If you have exceeded your Medicare therapy Cap amount YES ☐ NO ☐

Insurance Information.

Primary Insurance		Secondary Insurance	
Payor/Plan Name	Type	Payor/Plan Name	Type
Policy ID	Group ID#	Policy ID	Group ID#

Patient or Guardian Signature: ____ **Date:** ________________

ENCORE PHYSICAL THERAPY

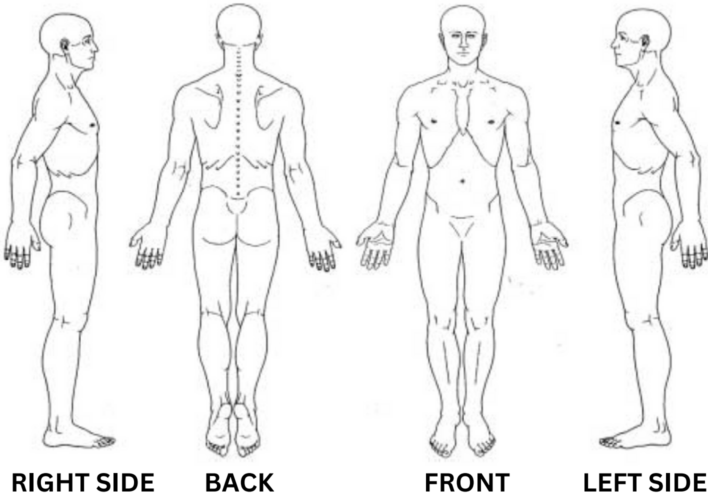
PATIENT NAME: ______________________________ DATE: __/__/____

1. What is the reason for coming to Physical Therapy?

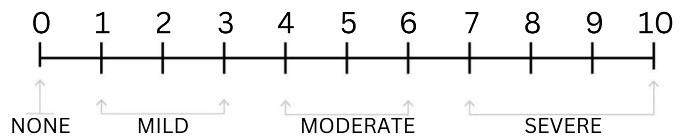
____

____

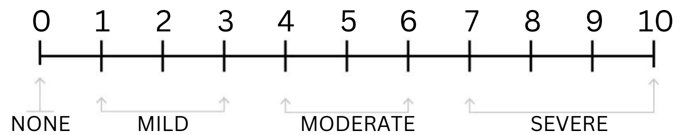
Please mark areas of pain



2. How would you rate your pain in **past 24 Hours**?



3. How would you rate your pain in the **past week**?



4. How did this injury occur?

____

5. What makes your symptoms **better**?

____

6. What makes your symptoms **worst**?

____

7. My symptoms are:

☐ New ☐ Chronic ☐ Intermittent ☐ Constant

8. Please describe your pain from the below symptoms: (Check all that apply)

☐ Dull Ache ☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Burning ☐ Shooting ☐ Severe ☐ Tingling
☐ Numbness ☐ Other/ Additional pain not listed above: ______________________________

9. Have you had any imaging performed for the above injury

☐ Xray ☐ CT scan ☐ MRI ☐ Other: ______________________

11. Have you been hospitalized for the present condition? ☐ Yes ☐ No
If Yes, date: _______________

12. Have you had surgery for the present condition? If Yes, date: _____________________
If yes, surgery type:____

13. Have you had any falls this past year ? ☐Yes ☐No If Yes, how many?__________

MEDICAL HISTORY (Check all that apply)

☐ Angina
☐ Anxiety or Panic Disorders
☐ Arthritis (RA, OA)
☐ Asthma
☐ Allergies
☐ Bleeding Disorders
☐ Bowel / Bladder Abnormalities
☐ Cancer/Tumor
☐ Chronic Obstructive Pulmonary Disease (COPD)
☐ Congestive Heart Failure (CHF)
☐ Degenerative Disc Disease (back disease, spinal stenosis, severe chronic back pain)
☐ Depression
☐ Diabetes
☐ Dizzy or Fainting Spells
☐ Emphysema
☐ Epilepsy or Seizure Disorder
☐ Fracture
☐ Headaches
☐ Hearing Impairment
☐ Heart Attack
☐ Hepatitis A, B, C
☐ Hernia
☐ High Blood Pressure
☐ Hypoglycemia
☐ Immunosuppressant Condition or Medication
☐ Kidney Problems
☐ Liver / Gallbladder Problems
☐ Metal Implants
☐ Multiple Sclerosis
☐ Nausea / Vomiting
☐ Osteoporosis
☐ Pacemaker
☐ Parkinson's Disease
☐ Peripheral Vascular disease
☐ Pregnancy
☐ Ringing in Your Ears
☐ Sexual Dysfunction
☐ Skin Abnormalities
☐ Smoking
☐ Stroke or TIA
☐ Upper Gastrointestinal Disease (ulcer, hernia, reflux)
☐ Visual Impairment (cataracts, glaucoma, macular degeneration)
☐ Tuberculosis
☐ Weight loss in the past 3 month of more then 10 lbs

To be filled with your therapist

14 . List of Past surgeries and medical implants.

_______________ _______________ _______________ _______________

15 . What all medications are you currently taking including prescription and over the counter medication.

_______________ _______________ _______________ _______________

_______________ _______________ _______________ _______________

The above information provided are true and accurate to the best of my knowledge:

Patient or Legal Guardian Name: ____

Patient or Legal Guardian Signature:_________________________ **Date:** ____________

CONSENT TO TREAT

I, ___________________________________, do hereby agree and give my consent for Encore Physical Therapy to provide medical care and treatment which is considered necessary and proper in the diagnosing or treating of my care.

RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

Benefit Assignment/Release of Information I hereby authorize the release of any medical information necessary for processing insurance claims and payment of the medical benefits for myself or the party who accepts assignment of benefits on my behalf. I authorize Encore Physical Therapy to release all medical information and records to any/all entities involved in my care. I also authorize my insurance carrier(s) to make payment directly to Encore Physical Therapy.

A photocopy of this assignment is to be considered as valid as the original.

NO SHOW / SAME DAY CANCELLATION POLICY

Our staff works hard to offer you an appointment that is convenient for you. We understand that there are times when you must miss an appointment due to emergencies or other obligations. If circumstances prevent you from keeping your appointment**, please call the office at least 24 hours in advance to reschedule.**

If an appointment is not cancelled at least 24 hours in advance, you will be charged a thirty-dollar ($30) fee; this fee will not be covered by your insurance company.

If you neglect to notify us 24 hours in advance or miss your scheduled appointment, a member of our Encore Physical Therapy staff will call to remind you of the miss appointment and offer you an opportunity to reschedule the appointment within the same business week. If we are unable to reach you on the day of the visit or you are unable to reschedule within the same business week, the inconvenience fee will be applied to the account and the patient will be invoiced.

Please understand that our policy is in place to assure that we maintain a superior standard of care for all our patients. Additionally, missed appointments prevent us from caring for other patients that may need our services at that time.

Patient or Guardian's Name: ____

Patient or Guardian's Signature: _______________________________ Date: __________________

FINANCIAL POLICY STATEMENT

SELF-PAY, INSURANCE & NON-CONTRACTED PLANS:

All charges are due and payable at the time of service. We accept cash, checks, and major credit cards. We may reschedule the appointment if payment is not made prior to the services rendered.

Patients must check if a referral from their Primary Care Physician (PCP) is needed. If not obtained or verified, they can reschedule. If they proceed without a referral, their health plan may not cover charges, and they'll be responsible for all costs incurred at Encore Physical Therapy.

If any payments are made directly to you for the services rendered by Encore Physical Therapy, you must promptly remit such payment directly to Encore Physical Therapy or be solely responsible for the entire bill.

Patients are expected to pay co-payments or deductibles upfront during service. Monthly finance charges apply to unpaid balances and are the patient's responsibility. Prior to the first visit, the clinic estimates out-of-pocket expenses by contacting the patient's insurance, though it's subject to change. Any adjustments will be reflected in a subsequent statement after receiving insurance information.

Encore Physical Therapy bills patients' insurance providers with a 45-day payment expectation. If an insurer doesn't pay on time and the patient is responsible, the patient must cover the cost. If an insurer delays or denies payment for over 90 days, the patient becomes liable for both portions. Any eventual insurer payment is credited to the patient's account and refunded as per policy.

I acknowledge that I have read, understood, and accept each paragraph stated above.

Patient or Guardian’s Name: ____

Patient or Guardian’s Signature: ______________________________ Date: _________________