Apex Physical Therapy

825 Cromwell Ave
Suite Q
Rocky Hill, CT 06067

Phone: (860)257-3779
Fax: (860)257-3780
Web: www.apexptct.com

REGISTRATION FORM

Patient Name: _____
Last First MI

Birthdate: _____ Sex: M or F Marital Status: Married Single Other

SSN: _____ (REQUIRED FOR MEDICARE AND WORKERS COMP.)

Address: _____

City: _____State: _____ Zip Code: _____

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

E-mail: _____

Emergency Contact/Relationship: _____Phone: _____

Do you want us to send you Appointment reminder: yes, or no If yes then E-mail, Text or Voice Call?

How did you hear about us: Doctor / Friend / Family / Internet / Paper Ad / Drive-by or Other?

Employer: _____Occupation: _____

Employer's Address: _____City: _____State: _____ Zip Code: _____

Employer phone number: _____

Have you received physical therapy services this year? yes or no

Referring Physician: _____ Phone: _____

Is your problem related to a personal/ Motor vehicle or Workers comp injury? yes or no

If yes do you have an attorney? yes or no

Attorney's name: _____ Phone: _____

Attorney's address: _____

This information will be used for billing purposes, please present your insurance card and driver license (or photo ID) to the front desk staff.
I have reviewed the above information and verify that it is correct.

Patient's/Guardian signature: _____ Date: _____

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PATIENT MEDICAL HISTORY

Name: _____ Referring Physician: _____

Have you had surgery: YES NO Type of surgery _____

Are you currently taking any prescription or non-prescription medications? YES NO

List medications: _____ _____ _____

_____ _____ _____

Are you allergic to any medications? YES NO

Have you had any medical diagnostic test for this current problem: Blood work X-rays MRI/Scan Other

Results if known: _____

Do you have or have had any of the following medical conditions? (Check one)

	YES	NO	Notes
Cardiac/respiratory problem	___	___	_____
Stroke/TIA/Epilepsy/Seizure/Parkinsonism	___	___	_____
Endocrine disorders/Diabetes	___	___	_____
Cancer/Chemotherapy/Radiation	___	___	_____
Arthritis/swollen joints/musculoskeletal problems	___	___	_____
Osteoporosis	___	___	_____
Headaches/dizziness	___	___	_____
Are you pregnant?	___	___	_____
Emotional/psychological problems	___	___	_____
Allergies	___	___	_____

Describe your current symptoms/ problem: _____

_____

List any other information that would assist us in your care: _____

_____

Do you participate in any sporting activities? YES NO If yes, please list: _____

Patient/Guardian Signature: _____ Date: _____

Clinicians Initials: _____ Date: _____

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INSURANCE INFORMATION FORM

Patient Name: _____
Last First MI

INSURANCE INFORMATION

Primary Insurance Name: _____Phone: _____

Policy/Claim#: _____Group #: _____

Secondary Insurance Name: _____Phone: _____

Policy/Claim#: _____Group #: _____

☐ Self-Pay- (please see self-pay agreement)

ONLY COMPLETE THE SUBSCRIBER INFORMATION IF THE PRIMARY OR SECONDARY POLICY HOLDER IS NOT THE PATIENT

SUBSCRIBER INFORMATION

Relation to patient: Self _____Spouse _____ Parent _____ Other _____

Name: _____
Last First MI

Birthdate: _____ Sex: M or F SSN: _____

Address: _____

City: _____State: _____Zip Code: _____

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

Employer Name: _____Occupation: _____

WORKER'S COMP INJURY/ MVA or OTHER INJURY (circle one)

Policy/Claim/Case number: _____ Date of Accident /Injury: _____

Attorney/Adjuster's name: _____

Phone: _____ Fax: _____

Case Manager's name: _____

Phone: _____ Fax: _____

Auto/Liable Insurance Name: _____

Address: _____

Phone: _____ Fax: _____

If Motor Vehicle Accident were you: Driver or Passenger

Where and how accident occurred_____

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Consent Form

CONSENT TO RECEIVE CARE & TREATMENT

I, the undersigned, do hereby agree and give my consent to Apex Physical Therapy, LLC to provide necessary assessment, care and treatment that is considered necessary and proper in diagnosing or treating his/her physical and mental condition.

AUTHORIZATION BENEFIT ASSIGNMENT - FINANCIAL RESPONSIBILITY

I authorize Apex Physical Therapy, LLC to release to the insurance carrier any information needed for the payment of any claim. I authorize payment to Apex Physical Therapy, LLC from my insurance carrier or third party payer. I agree to pay any applicable co-payments at the time of service and coinsurance and/or deductibles as agreed between Apex Physical Therapy, LLC and me. I understand that my insurance benefits may not cover all charges and that I am responsible for those charges not covered by my health insurance or third party payer. I authorize Apex Physical Therapy, LLC, to release all information necessary, including medical records, to secure payment.

AUTHORIZATION USE AND DISCLOSURE OF HEALTH INFORMATION

I authorize Apex Physical Therapy, LLC to use and disclose my protected health information to carry out treatment, Consultation, payment activities and health care operations. I authorize Apex Physical Therapy, LLC to obtain or release my medical/health information from and/or to health care professionals and/or individuals involved in the provision or payment of my care. Additionally, I authorize Apex Physical Therapy, LLC to release/disclose my health information to the following:

Name/Names: _____ Relationship: _____

I understand that I have the right to refuse to sign, amend or revoke this authorization by sending a written notice. I also understand that refusing to sign this document will not affect my rights to seek care and treatment at this facility

NOTICE OF PRIVACY

I received and/or read the Notice of Privacy Practices for the office Apex Physical Therapy, LLC and understand my rights contained in the notice

SIGNATURE for CONSENT

By my signature below I acknowledge that I have read, understand and agree to the terms and conditions contained in the Consent for Care and Treatment, the Authorization to release all information necessary to secure payment and the Consent For Use and Disclosure of Health Information.

Patient's/Guardian signature: _____ Date: _____

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NO SHOW/ CANCELLATION POLICY

Please understand that we set aside appointment times for each patient. We ask that you call at least 24 hours prior to your scheduled appointment to cancel so that we may provide other patients the care during that time.

We understand that you may miss your appointments due to emergencies, so contact our office so we may accommodate other patients in your time.

Please be informed that there is a $50.00 fee for missed appointments and NOSHOW. This fee has to be paid in full before you are seen again in the office. This fee is not billed to your insurance or workers comp.

We apologize for any inconvenience but hope that you understand that we want the best for all our patients.

Patients Name (Please print) _____

Patient/ Guardian signature _____

Date _____