



ACCELERATING YOUR REHAB, ENHANCING YOUR LIFESTYLE.

## PATIENT REGISTRATION Motor Vehicle Accident

Area of Injury to be treated \_\_\_\_\_ Today's Date \_\_\_\_\_

Name \_\_\_\_\_  
First MI Last

Address \_\_\_\_\_  
Street PO Box Apt #

Address \_\_\_\_\_  
City State Zip

Home Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cell Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Male or Female Marital Status M S D

Guardian's SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Patient's Date of Birth \_\_\_\_\_ E-Mail : \_\_\_\_\_

Guardian's Date of Birth \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**Employer Information** Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_  
Street PO Box Apt #

Address \_\_\_\_\_  
City State Zip

### **Physician Information**

**Primary Care Physician Name** \_\_\_\_\_

Address \_\_\_\_\_  
Street City ST Zip

Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Fax \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Referring Physician Name** \_\_\_\_\_

Address \_\_\_\_\_  
Street City ST Zip

Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Fax \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Have you had physical therapy for this accident before? \_\_\_ No \_\_\_ Yes If yes, when? \_\_\_\_\_

### **Motor Vehicle Claim Information**

Claim Number \_\_\_\_\_ Insured Name \_\_\_\_\_

Have you completed and returned a Personal Injury Protection application to insurance company? \_\_\_\_\_

Insurance Company Name \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Claims Adjuster \_\_\_\_\_

**ATTORNEY:** Name & telephone number \_\_\_\_\_

Attorney address: \_\_\_\_\_

**Health Insurance Information**

Primary Insured Name \_\_\_\_\_ Insured Date of Birth \_\_\_\_\_

Relationship to insured \_\_\_\_\_ Insured Phone # \_\_\_\_\_

Insured Address if Different from Patient:

Address \_\_\_\_\_

Street City ST Zip

Health Insurance Co Name \_\_\_\_\_ Ins Phone # \_\_\_\_\_

Address \_\_\_\_\_

Street City State Zip

Group Number \_\_\_\_\_ ID Number \_\_\_\_\_

Contact Name \_\_\_\_\_

**CONSENT TO TREATMENT**

I hereby authorize the professional staff at **Accelerated Physical Therapy, Inc** to examine and treat me with physical therapy for the injury I have been referred here for or referred myself to.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Printed Name

\_\_\_\_\_  
Staff Witness Signature

\_\_\_\_\_  
Parent or Guardian Signature (if under 18)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian Printed Name

\_\_\_\_\_  
Staff Witness Signature

**ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO HEALTH PROVIDER**

Insurance Company/Companies Name(s) \_\_\_\_\_

**I hereby instruct the above named insurance company/companies to pay by check made out to and mailed directly to: Accelerated Physical Therapy, Inc for professional or medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy. I understand that **Accelerated Physical Therapy, Inc** complies with HIPPA and will protect my Protected Health Information (PHI) and will use it as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed and full payment is received. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney for the purpose of securing payment under this policy of insurance or to any Medical Provider associated with my case to effectively treat me. The authorization is in effect until 90 days from the date the last bill is collected. **A \$35 fee will be assessed for any returned checks. Monthly statements will be sent regarding your balance. If no response after the third statement, your account will be turned over to the Collection agency. A 35% collection fee will be added to any account which is turned over to the collection agency for non-payment. Legal fees may occur and sought for payment which will add a 50% collection fee to your balance.****

**HIPPA REGULATIONS** A photocopy of this Assignment shall be considered effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance under the HIPPA guidelines.

\_\_\_\_\_  
Patient Name (Printed) Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Parent or Guardian (Printed)

\_\_\_\_\_  
Relationship Parent or Guardian Signature

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

# MEDICAL HISTORY

Patient Name \_\_\_\_\_ Age \_\_\_\_\_

Type of Injury/Condition \_\_\_\_\_

Onset/Injury Date \_\_\_\_\_

Type of Surgery & Date \_\_\_\_\_

Next Doctor's Appointment \_\_\_\_\_

Describe previous treatment for this condition \_\_\_\_\_

Have you received chiropractic treatment this year? Yes / No

**Have you had any imaging performed:**

- X-Ray
- MRI
- CT Scan
- Doppler
- Ultrasound

**Have you recently noted:**

- Weight Loss / Gain
- Weakness
- Pregnant / IUD
- Pain at Night
- Nausea / Vomiting
- Fever / Chills / Sweats
- Headaches
- Cramps in Legs When Walking
- Fatigue
- Numbness / Tingling
- Change in Vision / Hearing
- Insomnia

**Do you have now or have you ever had any of the following:**

- Surgeries
- Sprains / Strains
- Heart Problems
- Circulation Problems / Clots
- Easy Bruising / Bleeding
- Indigestions / Heartburn
- Rheumatoid Arthritis
- Any previous injury that may affect current care \_\_\_\_\_
- Loss of Consciousness
- Diabetes
- Cancer
- Asthma / Breathing Problems
- Leg / Ankle Swelling
- Fainting
- Fractures
- Blood Pressure Problems
- Motor Vehicle Accident
- Lung Disease
- Urinary Problems / Infections
- Allergies / Skin Sensitivity

Explain and give approximate dates for any items indicated above \_\_\_\_\_

Are you currently taking medications? Yes / No Name or Type of Medication \_\_\_\_\_

Type of Pain: Sharp / Burning / Aching / Tingling / Numbness / Other \_\_\_\_\_

Rate your pain At its worst: 0 1 2 3 4 5 6 7 8 9 10 At its best: 0 1 2 3 4 5 6 7 8 9 10

What do you hope to get out of your treatment? \_\_\_\_\_

What are your physical or fitness goals? \_\_\_\_\_

\_\_\_\_\_  
**Patient or Personal Representative Signature**

\_\_\_\_\_  
**Date**

