DRAC Physical Therapy
Patient Registration Form
Please Print Clearly

PATIENT INFORMATION

TODAY'S DATE:___/___/___

LAST NAME:______________________________ FIRST NAME:__________________________MI:_________

SEX: ☐ M ☐ F HOME ADDRESS:____

CITY:_______________________________________ STATE:__________________ZIP CODE:____________

HOME PHONE:________________________________ CELL PHONE:________________________________

DATE OF BIRTH:_____/______/______ SOCIAL SECURITY #:_________-___________-_____________

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ OTHER EMPLOYED: ☐ YES ☐ NO

EMPLOYER/SCHOOL:______________________________________ WORK PHONE:_____________________

EMAIL ADDRESS: ____

IN CASE OF EMERGENCY CALL:

NAME:_______________________________ PH NUMBER# __________________________________

DOCTOR'S INFORMATION

REFERRING DR:____

LOCATION & PHONE NUMBER:____

PRIMARY CARE DR:____

LOCATION & PHONE NUMBER:____

HAVE YOU HAD PHYSICAL THERAPY THIS CALENDAR YEAR?

YES: ○ NO: ○

HAVE YOU HAD HOME PHYSICAL THERAPY OR VNA SERVICES?

YES: ○ NO: ○

IS THIS INJURY THE RESULT OF A SLIP AND FALL?

YES: ○ NO: ○

IF YES WHERE DID YOU FALL :____

INSURANCE INFORMATION

* FAILURE TO PROVIDE ALL NEEDED INSURANCE INFORMATION RESULTS IN CHARGES DIRECTLY TO THE PATIENT OR GUARANTOR**

PRIMARY INSURANCE:________________________________ID#______________________________________

GROUP# (if applicable):_____________________POLICY HOLDER:____________________________________

DOB:____/____/____ SSN:____-____-_____ RELATIONSHIP TO POLICY HOLDER:____________________

SECONDARY INSURANCE:_________________________________ ID#__________________________________

GROUP# (if applicable):__________________________POLICY HOLDER:_______________________________

DOB:____/____/____ SSN:____-____-_____ RELATIONSHIP TO POLICY HOLDER:____________________

IF YOU HAD A CAR OR WORK RELATED ACCIDENT PLEASE COMPETE THIS SECTION:

If work related see section 1, If Auto related skip to section 2

Section 1-Workers Compensation Claims

DATE OF ACCIDENT:__________________________CLAIM NUMBER:________________________________

Name of
Employer:____Phone:_________________________________

Ins Company Name:____

Address of Ins Company:____

Claims Adjuster:__________________________________ Adjuster Ph Number:_________________________

Section 2- Motor Vehicle Claims **(Note all Motor Vehicle cases must also provide health insurance information)**

DATE OF ACCIDENT:__________________________CLAIM NUMBER:________________________________

Ins Company Name:____

Address of Ins Company:____

Claims Adjuster:__________________________________ Adjuster Ph Number:_________________________

Have you returned your PIP Application to Ins Company? Yes__________ No_____________

Have you exhausted your PIP yet? Yes____________ No______________

Lawyers Name and Phone Number:____

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NO SHOW/LATE CANCELLATION POLICY

AS A CONVIENCE TO OUR PATIENTS WE ARE ABLE TO SEND OUT AUTOMATIC REMINDERS 24 HOURS BEFORE EACH APPOINTMENT. THESE REMINDERS WILL ENSURE YOU ARRIVE ON THE RIGHT DAY AT THE RIGHT TIME, THUS AVOIDING A LATE CANCELLATION OR NO SHOW FEE. PLEASE SELECT A REMINDER METHOD BELOW AND UNDERSTAND ANY APPOINTMENT NOT CANCELLED WITHIN **24 HOURS** OR SCHEDULED AND NOT ATTENDED IS SUBJECT TO OUR $35 FEE. **THIS FEE MUST BE PAID BEFORE YOUR NEXT SESSION.** ANY PATIENT WITH 3 OR MORE NO SHOW/LATE CANCELLATION'S WILL BE DISCHARGED FROM OUR CARE DUE TO NON COMPLIANCE. THANK YOU FOR YOUR COOPERATION.

I WOULD LIKE TO BE REMINDED VIA:

☐ PHONE CALL: (_______)_______-__________

☐ TEXT MESSAGE: (_______)_______-__________

☐ EMAIL: ________________________________@ ___________.COM

Please note all reminders are done through our computer system and you are unable to cancel via the automated emails, calls or text messages. Cancellations must be made via phone to our office, if you are calling outside of office hours please make sure you leave a clear and detailed message.

NO SHOW/CANCELLATION POLICY AGREEMENT

I UNDERSTAND ANY APPOINTMENT I SCHEDULE AND DO NOT ATTEND **OR** SCHEDULE AND DO NOT CANCEL WITHIN 24 HOURS WARRANTS A $35 NO SHOW FEE WHICH MUST BE PAID BEFORE MY NEXT APPOINTMENT.

SIGNATURE:____________________________________DATE:______________

PATIENT INFORMATION

NAME:__________________________________**OCCUPATION:**______________________**AGE:**__________

HEIGHT:_____**FT**____**IN** **WEIGHT:**__________

DIAGNOSIS AS STATED TO YOU BY YOUR PHYSICIAN:____

____

HOW DID THIS INJURY/EXACERBATION OCCUR: ____

____

HAVE YOU HAD SURGERY FOR THIS PRESENT CONDITION? ☐YES ☐ NO IF YES, DATE OF SURGERY:_______

HAVE YOU RECEIVED PREVIOUS TREATMENT FOR THIS CONDITION? ☐ YES ☐ NO IF YES, DATE:__________

IF YES, PLEASE SUMMARIZE:____

HAVE YOU HAD ANY X-RAYS, MRI'S OR DIAGNOSTIC TESTING FOR YOUR CONDTION? ☐ YES ☐NO

IF YES, PLEASE EXPLAIN FINDINGS:____

Please rate your pain on a scale from 0-10 (0 being no pain, 10 being emergency room pain):

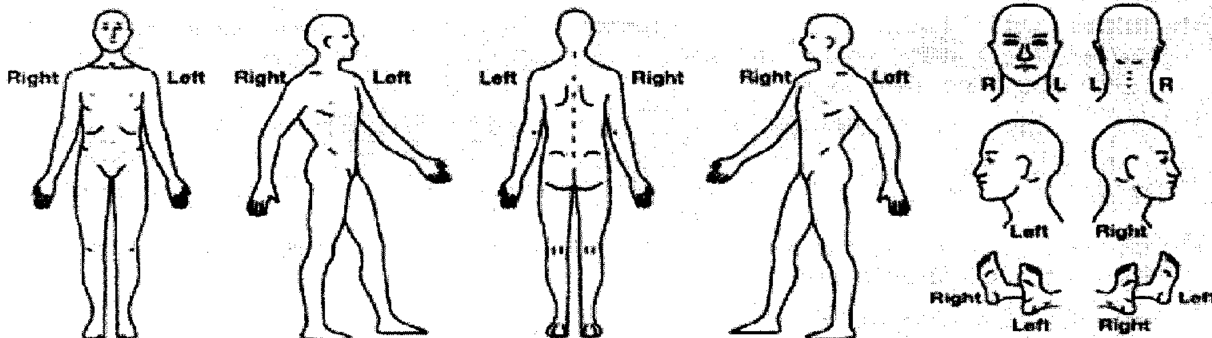
0----1----2----3----4----5----6----7----8----9----10

At Worst, My Pain Is: ___/10

My Current Pain Is: ___/10

At Best, My Pain Is: ___/10

How would you describe your pain (please circle): Deep/achy, Throbbing, Sharp, Electric, Burning, Pins/Needles, Shooting, Worse in the AM, Worse in the PM, Worse at night, Constant, Intermittent



Please mark to the best of your ability where your pain is.

PATIENT INFORMATION

Do you now, or have you ever had any of the following (please circle):

-HEART CONDITION YES NO
-TYPE 1 DIABETES YES NO
-TYPE 2 DIABETES YES NO
-HIGH BLOOD PRESSURE YES NO
- IF YES, LIST NORMAL FOR YOU ___/___
-PACEMAKER YES NO
-ASTHMA YES NO
-KIDNEY PROBLEMS YES NO
-ANXIETY YES NO
-HERNIA YES NO
-BONE DENSITY/FRACTURE YES NO
-BOWEL/BLADDER YES NO
-PINS & NEEDLES YES NO
-CIRCULATORY DISEASE YES NO
-RHEUMATOID ARTHRITIS YES NO
-LUPUS YES NO
-PARKINSON'S DISEASE YES NO

-SENSITIVE TO HEAT/COLD YES NO
-OTHER ALLERGIES YES NO
-FIBROMYALGIA YES NO
-HEADACHES YES/NO
-PREVIOUS SURGERY YES NO
-SEIZURES YES NO
-METAL IMPLANTS YES NO
-DIZZINESS YES NO
-CANCER YES NO
-CURRENT PREGNANCY YES NO
-OSTEOPOROSIS YES NO
-RECENT WEIGHT LOSS YES NO
-SYMPTOMS IN BOTH ARMS/LEGS YES NO
-STROKE YES NO
-TRAUMATIC BRAIN INJURY YES NO

If yes to any of the above, please use reverse side to further explain

ARE YOU PRESENTLY TAKING ANY MEDICATIONS? (if yes, list below or provide staff with a list to scan into your chart) YES__________ NO__________

MEDICATION NAME	DOSAGE	REASON

PLEASE INITIAL AFTER READING THE FOLLOWING TERMS!!

RELEASE OF MEDICAL RECORDS:
I hereby consent to the release of any and all records and information or copies related to my physician, nurse safety officer, rehabilitation specialist, insurance company or attorney when appropriate. I also understand that regular reports will be provided to them as requested and as they relate to my treatment and progress.

Your initials_______

DEDUCTIBLE AND CO-INSURANCE AGREEMENTS:
I hereby agree to pay all the deductible and co-insurance payments if required by the policies of my insurance coverage. I further agree to pay these bills upon notification. Failure to comply with reimbursement of balances owed may lead to collection activity.

Your initials_______

PREVIOUS TREATMENT:
I understand that it is my responsibility to inform staff at DRAC PT if I have received medical treatment elsewhere for the same or any other injuries because I might have used part of, if not all my insurance benefits. It is also my responsibility to find out the availability of my physical therapy benefit from my insurance company if I have been treated for the same or other injuries before. By not providing this important information, I will be held responsible for the claims in full that are rejected by my insurance company due to benefit exhaustion.

Your initials_______

INSURANCE BENEFIT AND REFERRALS:
I understand that it is my responsibility to verify physical therapy benefits with my insurance company. If my insurance policy requires referrals from a dedicated source, (for example, primary care physician), I am responsible to provide one at the time of my initial visit, and to provide more as needed to continue treatment. I will keep track of my visits not to exceed the number of visits authorized on the referral and not go beyond the expiration date. I will be responsible for visits that are not covered by referrals. As courtesy, staff at DRAC PT will inform me when a referral is needed.

Your initials_______

CONSENT TO RENDER PAYMENT:
I hereby authorize the payment of medical benefits to DRAC PT for services rendered to me, or others for whose medical benefit I am responsible. DRAC PT agrees to bill my insurance company as a courtesy; however, should the insurance company pend or deny claims beyond 60 days of submission, I will be responsible for payment in full to DRAC PT within upon notification from insurance company or DRAC PT billing department.

Your initials_______

CO-PAY:
I understand that my co-pay is due at the time of service. DRAC PT reserves the right to reschedule appointments for outstanding balances.

Your initials_______

PRIVACY NOTICE:
I have received DRAC PT's Notice of Privacy Practices.

Your initials_______

TREATING THERAPIST
I UNDERSTAND THAT AFTER MY EVALUATION TODAY, MY APPOINTMENTS MAY BE BOOKED WITH ANOTHER THERAPIST. WE WOULD LIKE TO APOLOGIZE FOR ANY INCONVENIENCE THIS MAY CAUSE TO YOU. Your initials_______

By signing below, I acknowledge that I have agreed to the above mentioned policies, and consent for DRAC Physical Therapy, Inc to render treatment.

SIGNATURE:_________________________________ **DATE:**____________

THIS PAGE IS OPTIONAL

AUTHORIZATION TO KEEP CREDIT CARD ON FILE

DRAC Physical Therapy
200 Providence Highway
Dedham, MA 02026
781-326-8332

By signing the bottom of this page, I authorize DRAC Physical Therapy to charge my credit card for C0-Payments/Balance due of charges not paid by my insurance (including no show fees). I understand this form is valid for one year from the date signed unless I cancel the authorization through written notice to DRAC Physical Therapy.

Signature: ________________________________ ***Date:*** ___________

Patient Name & Address: ____________________________________
____
____
____
____

Bankcard Payment Authorization:

________ *American Express*

________ *Visa*

________ *MasterCard*

________ *Discover*

Credit Card Account Number: ________________________________

Expiration Date: __________________

Name as shown on Credit Card: _______________________________

Cardholder Signature: ____________________________________