Appalachian Physical Therapy, Inc.

"There's a difference you can feel"

PATIENT REGISTRATION FORM

Patient's Name____ ☐ **Male** ☐ **Female** ________
(First) **(Middle Initial)** **(Last)**

Street Address____**Apt** ____**Mailing**_________________________________

City____**State**___________________________**Zip**__________________

Phone__________________________ **Cell Phone**______________________ **E-mail**________________________________

May we leave a message on your: Phone_________ **Cell Phone**________**Text Message**________ **E-mail**_______________

Social Security_______________________________________**Date of Birth**_____/____/________**Age**__________________

Father's Name ____________________________ **Date of Birth** ____/____/______ **Social Security**____________________

Father's Address ____ **Phone** _________________________

Father's Employer ____**Phone**__________________________

Address____

Mother's Name ____________________________ **Date of Birth** ____/____/______ **Social Security**____________________

Mother's Address ____ **Phone** _________________________

Mother's Employer ____ **Phone**_________________________

Address____

Date of injury, if known___________________ **Referring Physician** ____

Person who recommended our services if other than physician____

Person to Contact in Case of Emergency____**Phone**____________________

Have you been a patient here before?_____**Have you had physical therapy or chiropractic in the past 12 months?**_______

I desire that physical therapy services be provided to me and understand it will be my responsibility to pay for these services if my insurance does not pay or if my insurance benefits are paid to me inadvertently. I request that payment of authorized insurance benefits for services be preassigned to Appalachian Physical Therapy.

I understand that any balance remaining on my account after 60 days from the date of service is subject to interest charges at the rate of 2% per month. I understand I am responsible for all registered mail fees, court costs, and attorney fees incurred as a result of collection efforts on this account.

Patient Representative/
Legal Guardian____**Date**____________________

PROVIDER NOTICE
OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures: We use health information about you for treatment, billing, and healthcare operations. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax, or other methods. We may use or disclose identifiable health information about you without your authorization in several situations, but beyond those situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. We will not sell or use your health information without your authorization.

Your rights: In most cases, you have the right to look at or get a copy of health information about you. If you request copies, we may charge you a fee. You also have the right to receive a list of certain types of disclosures of your information that we made. You have the right to receive a copy of your healthcare record in a machine electronic format or a hard copy if a machine readable format is not available. We will complete your request within 30 days. You have the right to restrict the disclosure of healthcare information when payment for an item or service is paid out of pocket. If you believe that information in your record is incorrect, you have the right to request that we correct the existing information.

Our legal duty: We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and seek your acknowledgement of receipt of this notice. If we make a significant change in our policies, we will change our notice and post the new notice. We will notify affected individuals of a breach of unsecured protected healthcare information. *You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.*

Complaints: If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

If you have any questions or complaints, please contact:
Privacy Officer: Colleen Whiteford
Address: 171 East Springbrook Road
Broadway, VA 22815
Phone: (540) 901-9501

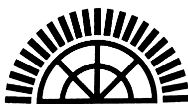
…………………………………………………………………………………………………

Acknowledgement of receipt of Notice of Privacy Practices:
Please sign your name and print your name and date on this acknowledgement form.

Patient Signature:____________________________________Date:_______________

Printed Name:_______________________________________

Patient Representative/Legal Guardian, if applicable:____________________________



Appalachian Physical Therapy, Inc.
211-L Central Park Avenue • Olmsted Village • Pinehurst, NC 28374 • (910)215-0541 • Fax (910)215-9886

Please provide us with the following important background information. If you do not understand a question please ask your therapist and they will assist you. Thank you!

Name: ______________________________________

- Please list any known allergies: ____
  ____
- Are you latex sensitive? Yes No
- Are you allergic to heat or cold on your skin? Yes No Unsure
- Are you pregnant or think you might be pregnant? Yes No
- Do you wear a pacemaker? Yes No

Please indicate whether you are under the care of any of the following health care providers:

- ☐ Medical Doctor
- ☐ Osteopath
- ☐ Dentist
- ☐ Psychiatrist/Psychologist
- ☐ Physical therapist
- ☐ Chiropractor
- ☐ Other (please specify): _____________
  ____
  ____

If you have seen any of the above within the last three months, please describe for what reason (illness, medical condition, physical, etc.): ____
____

MEDICAL/SURGICAL HISTORY

- Please indicate if you have ever been diagnosed with any of the following conditions:
  - ☐ Arthritis
  - ☐ Broken bones/fracture
  - ☐ Osteoporosis
  - ☐ Blood disorders
  - ☐ Circulation/vascular problems
  - ☐ Heart problems
  - ☐ Hypertension (high blood pressure)
  - ☐ Lung problems
  - ☐ Stroke
  - ☐ Diabetes
  - ☐ Hypoglycemia
  - ☐ Head injury
  - ☐ Multiple sclerosis
  - ☐ Chemical dependency
  - ☐ Muscular dystrophy
  - ☐ Parkinson's disease
  - ☐ Seizures/epilepsy
  - ☐ Developmental or growth problems
  - ☐ Thyroid problems
  - ☐ Kidney problems
  - ☐ Skin disease
  - ☐ Cancer
  - ☐ Repeated infections
  - ☐ Depression
  - ☐ Infectious disease
  - ☐ Ulcers/stomach problems
  - ☐ Alcohol abuse
  - ☐ Other: ______________________________

- Within the past year, have you had any of the following symptoms?
  - ☐ Chest pain
  - ☐ Heart palpitations
  - ☐ Cough
  - ☐ Hoarseness
  - ☐ Shortness of breath
  - ☐ Dizziness or blackouts
  - ☐ Coordination problems
  - ☐ Weakness in arms/legs
  - ☐ Loss of balance
  - ☐ Difficulty walking
  - ☐ Joint pain or swelling
  - ☐ Difficulty sleeping
  - ☐ Loss of appetite
  - ☐ Nausea/vomiting
  - ☐ Difficulty swallowing
  - ☐ Bowel problems
  - ☐ Weight loss/gain
  - ☐ Urinary problems
  - ☐ Fever/chills/sweats
  - ☐ Headaches
  - ☐ Hearing problems
  - ☐ Vision problems
  - ☐ Fatigue
  - ☐ Numbness/tingling
  - ☐ Other: ____

- Have you had testing performed? MRI X-Rays CT Scan Other__________ When Performed?___________
  Where were the test(s) performed? RMH UVA Doctor's Office Other_________________________

- Please list any surgeries or hospitalizations, including the approximate date and reason:
  ____
  ____
  ____

- Please describe any significant injuries for which you have been treated and the approximate date of injury:
  ____
  ____
  ____
  ____

- Have you ever been involved in a motor vehicle accident? ☐ Yes ☐ No
  If yes, please list the approximate date(s): ____

FAMILY HISTORY

- Please indicate whether anyone in your immediate family (parents, siblings, grandparents) have been diagnosed with the following and list the age of onset if known:

  ☐ Heart disease ____________________
  ☐ Hypertension ____________________
  ☐ Stroke ____________________
  ☐ Diabetes ____________________
  ☐ Cancer ____________________
  ☐ Psychological ____________________
  ☐ Arthritis ____________________
  ☐ Osteoporosis ____________________
  ☐ Other: ____________________

MEDICATIONS

- Please list any prescription medications you are currently taking: ______________________________
  ____
  ____
  ____

- Are you taking any of the following nonprescription medications?
  ☐ Aspirin
  ☐ Advil/Aleve/Motrin/ Ibuprofen
  ☐ Tylenol
  ☐ Antihistamines
  ☐ Herbal supplements
  ☐ Decongestants
  ☐ Laxatives
  ☐ Antacid
  ☐ Vitamins
  ☐ Other: ____________________

SOCIAL/HEALTH HABITS

- Do you currently use tobacco products? ☐ Yes ☐ No
  - If yes, how many packs per day do you smoke? ________

- Have you used tobacco products in the past? ☐ Yes ☐ No
  - If yes, in what year did you quit? _______

- How many caffeinated beverages do you drink per day? ________

- Do you exercise beyond normal daily activities and chores? ☐ Yes ☐ No
  - If yes, please describe the type of exercise, how many times per week, and for how long each day.
    ____

Patient Signature: ____ Date: ______________

Therapist Signature: ______________________________________ Date: ______________