BREAKTHROUGH PHYSICAL THERAPY, INC
REGISTRATION FORM
(Please complete all questions)

OFFICE USE ONLY

TREATING THERAPIST: ______________________ NP RS UPD NBP

DATE ________ LAST NAME ______________________ FIRST NAME ______________ SEX ○ M ○ F

ADDR ______________________________ CITY ____________________ ST ____ ZIP ______

( ) HOME PH # ____________ ( ) WORK PH # ____________ ( ) CELL PH # ____________

Please indicate by placing number in parentheses the order in which to call when trying to reach you.

E-MAIL ADDRESS ______________________ DL/ ID # ______________ ST ____ EXP ______

DOB ______________ AGE ____ SSN # ______________ STUDENT STATUS ○ FT ○ PT ○ NA

EMPLOYER ______________________ PHONE __________ EMPLOYMENT STATUS __________
(Either patient or responsible party)

MARITAL STATUS ______________ SPOUSE/OTHER NAME ______________________

SPOUSE'S/PARENT'S EMPLOYER ______________________ PHONE # ______________

RESPONSIBLE PARTY NAME (IF MINOR): ______________________________

RESPONSIBLE PARTY DOB ______________ RESPONSIBLE PARTY SSN # ______________

ADDR ______________________________ CITY ____________________ ST ____ ZIP ______

EMERGENCY CONTACT ______________________ RELATIONSHIP __________ PHONE # __________

WHO MAY WE THANK FOR YOUR REFERRAL OTHER THAN YOUR DOCTOR? ______________

REFERRING M.D. NAME ______________________________ PHONE # ______________

ADDRESS ______________________________ CITY ____________________ ST ____ ZIP ______

TREATMENT AREA (body part) ______________________ Frequency/Duration on Rx __________

WHO DO WE BILL? ○ HEALTH INSURANCE ○ MY AUTO INSURANCE ○ CASH PAY ○ MC

IF ACCIDENT, DATE OF INJURY ______________ CURRENTLY WORKING? ○ Y ○ N

PRIMARY INSURANCE CARRIER NAME ______________________________

CUSTOMER SERVICE PH # ______________ PROVIDER SERVICE PH # ______________

SUBSCRIBER'S NAME ______________________ DOB __________ RELATIONSHIP __________

SUBSCRIBER'S CLAIM #/I.D. # ______________________ GROUP # ______________

If Medicare is your secondary and not primary insurance, please explain why: ______________________

SECONDARY OR OTHER INSURANCE ______________________________

CUSTOMER SERVICE PH # ______________ PROVIDER SERVICE PH # ______________

SUBSCRIBER'S NAME ______________________ DOB __________ RELATIONSHIP __________

SUBSCRIBER'S CLAIM #/I.D.# ______________________ GROUP # ______________

Please initial here __________

BENEFITS AND MEDICAL RELEASE AUTHORIZATION: I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIM. I AUTHORIZE THAT PAYMENT OF MEDICAL BENEFITS SHALL BE PAID DIRECTLY TO BREAKTHROUGH PHYSICAL THERAPY. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE CARRIER. I HAVE READ ALL THE INFORMATION ON BOTH REGISTRATION FORM PAGES. I CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES IN MY HEALTH STATUS, INSURANCE, OR INFORMATION ON THE REGISTRATION FORMS.

______________________________ ______________

PATIENT SIGNATURE DATE

______________________________ ______________

PARENT/GUARDIAN SIGNATURE (IF PATIENT IS A MINOR) DATE

Advanced Patient Notice and Waiver

NOTE: You need to make a choice about receiving health care services.

Your Health Care insurer may deny physical therapy "benefit coverage" based on Medical Necessity as remarked on your carrier's Explanation of Benefit notifications. Insurers only pay for covered services. The fact that your insurer may not pay for a particular service doesn't mean you shouldn't receive it. There may be a good reason why your doctoror physical therapist recommends it. At this time, it is possible that your insurer may not pay for continued services. Ifcoverage is denied, you have the right to appeal your insurer's decision. Services may also be reduced or denied if you are receiving concurrent care at another facility. If this is the case, you may be financially responsible for this care as your carrier will not pay for both episodes of care on the same day.

Service description: Comprehensive rehabilitation program utilizing soft tissue and joint mobilization techniques, neuromuscular re-education, modalities, progressive Home Exercise Program (HEP) and patient education. Service may include ice, heat, ultrasound and electrical stimulation as needed.

Patient Acknowledgement and decision: Sign and Date below.

I WANT TO RECEIVE THESE SERVICES AND UNDERSTAND THAT MY INSURER ______________ WILL NOT DECIDE WHETHER TO PAY UNLESS I RECEIVE THESE SERVICES. PLEASE SUBMIT MY CLAIM(S). I UNDERSTAND THAT BREAKTHROUGH MAY BILL ME FOR SERVICES AND THAT I MAY HAVE TO PAY WHILE MY INSURER IS MAKING ITS DECISION. IF MY INSURER DOES PAY, BREAKTHROUGH WILL REFUND TO ME ANY PAYMENTS I MADE TO BREAKTHROUGH THAT ARE DUE TO ME. IF MY INSURER DENIES PAYMENT, I AGREE TO BE PERSONALLY AND FULLY RESPONSIBLE FOR PAYMENT. THAT IS, I WILL PAY PERSONALLY, OUT OF POCKET.

I represent and warrant that I am at least eighteen (18) years of age and that I have read this waiver, that I understand its terms and voluntarily sign it without any inducement.

______________________________ ______________

(PRINT NAME) PATIENT/GUARDIAN/RESPONSIBLE PARTY DATE

______________________________ ______________

(SIGNATURE) PATIENT/GUARDIAN/RESPONSIBLE PARTY DATE

______________________________ ______________

CLINIC REPRESENTATIVE DATE

Note: Your health information will be kept confidential. Any information we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your insurer, your health information on this form may be shared with your insurer. Your health information which your insurer sees will be kept confidential by your insurer.

BreakThrough

MEDICAL HISTORY

Patient Name ______________________ Age ________

Type of Injury / Condition ______________________ Onset / Injury Date ________

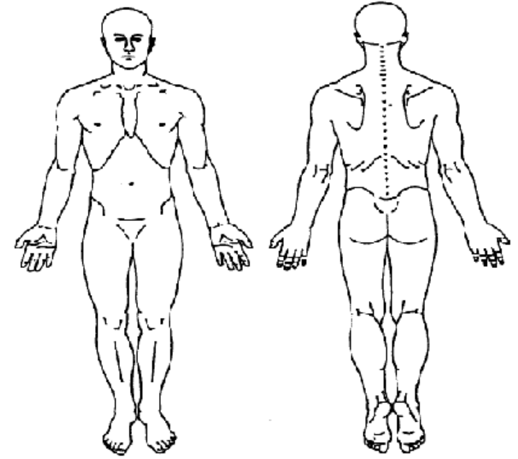
Occupation ______________________

Sports Activities / Exercise ______________________

Type of Surgery & Date ______________________

Next Doctor's Appointment? ______________________

Describe previous treatment for this condition



Please mark the area(s) of concern

Have you had any of the following tests:

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

What were the findings for the above?

Have you recently noted:

- ☐ Unexpected Weight Loss / Gain
- ☐ Weakness / Stumbling While Walking
- ☐ Changes in Bowel / Bladder Habits
- ☐ Pain at Night
- ☐ Difficulty Swallowing / Speaking
- ☐ Nausea / Vomiting / Dizziness
- ☐ Pain with Coughing / Sneezing
- ☐ Fainting
- ☐ Numbness / Tingling in the Saddle Area
- ☐ Numbness / Tingling in both Hands and Feet at the Same Time
- ☐ Fatigue
- ☐ Numbness / Tingling
- ☐ Change in Vision or Double Vision

Do you have now or have you ever had any of the following?

- ☐ Surgeries
- ☐ Sprains / Strains
- ☐ Heart Problems
- ☐ Circulation Problems / Clots
- ☐ Easy Bruising / Bleeding
- ☐ Pregnancy
- ☐ Loss of Consciousness
- ☐ Diabetes
- ☐ Cancer
- ☐ Asthma / Breathing Problems
- ☐ Indigestion / Heartburn
- ☐ Fractures
- ☐ Blood Pressure Problems
- ☐ Motor Vehicle Accident
- ☐ Osteoporosis / Osteopenia
- ☐ Allergies / Skin Sensitivity
- ☐ Any previous injury that may affect current care ______________________

Explain & 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 (1=minimal 10=severe): At its worst ________ At its best ________

What are your personal or fitness goals?

Is there anything else you would like to include or discuss with your physical therapist?