PATIENT REGISTRATION

Name: (Last) _____ (First) _____ (MI) _____ (Jr., Sr., etc.) Sex: M or F

Street Address: _____ Apt./Space: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Marital Status: _____

CONTACT INFORMATION (Check the box next to the best contact number)

□Home phone: _____ □Work Phone: _____ □Cell Phone: _____

Email address: _____

EMERGENCY CONTACT: _____ Relation: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

PARENT / RESPONSIBLE PARTY FOR PAYMENT: _____ Date of Birth: _____

Address: (If different from above) _____

City: _____ State: _____ Zip Code: _____ Phone: _____

INSURANCE INFORMATION

Primary Ins: _____ **Insured Name:** _____ **DOB:** _____

Secondary Ins: _____ **Insured Name:** _____ **DOB:** _____

On the job injury? □YES □NO

Worker's Comp Insurance Co. Date of Injury: _____ Claim #: _____ Adjuster's Name _____

Auto Accident? □YES □NO Date of Injury: _____ Claim #: _____ Adjuster's Name _____

Attorney's Name: _____ Attorney's Phone: _____

PREVIOUS THERAPY INFORMATION

Have you received any other Therapy Services this calendar year? □YES □NO

Have you received, or are you currently receiving Home Health Therapy? □YES □NO

If yes, please provide dates: _____ and the name of Home Health Agency: _____

Have you received, or are you currently receiving Chiropractic Treatment? □YES □NO

I hereby authorize payment of medical benefits to _____, for services furnished to me. I also hereby consent to have treatment and care as prescribed by my physician and / or recommended by the therapist. I also authorize the therapist to release any information in the course of my examination or treatment. This assignment will remain in effect until revoked by me in writing. A photocopy is to be considered as valid as the original. I HEREBY ACCEPT FINANCIAL RESPONSIBILITY FOR ALL CHARGES INCURRED WHETHER OR NOT I HAVE INSURANCE COVERAGE. VERIFICATION OF BENEFITS WE RECEIVE FROM YOUR INSURANCE COMPANY IS NOT A GUARANTEE OF PAYMENT.

_____ _____

Patient or Responsible Party Signature Date

MEDICAL HISTORY FORM

NAME: _____ DATE: _____
REFERRING PHYSICIAN: _____ DATE OF BIRTH: _____
FAMILY PHYSICIAN: _____

MEDICAL HISTORY

Is your current condition related to an injury? **Yes____** **No____**
If YES, was the injury related to: **Auto____** **Work____** **Other____** **Date of Injury** _____

Are there any lawsuits pending regarding your condition? **Yes____** **No____**

Have you received physical/speech therapy in the last year? **Yes____** **No____**
If YES, refer to your insurance policy for limitations.

Please check any of the following conditions you have or may have had in the past:

_____ Heart Disease	_____ Tuberculosis	_____ Asthma
_____ High Blood Pressure	_____ Currently Pregnant	_____ Stroke
_____ Heart Murmur	_____ Fatique/Energy Loss	_____ C.O.P.D.
_____ Mood Disorders	_____ Chest Pain/Discomfort	_____ Hepatitis
_____ Shortness of Breath	_____ Ankle Swelling	_____ Anemia
_____ Kidney Disease	_____ Epilepsy/Seizures	_____ Diabetes
_____ Dizzy Spells	_____ Allergies	_____ Hernia
_____ Headaches	_____ Cancer: Type_____	
_____ Loss of Bladder/Bowel Control	_____ Other: _____	

ORTHOPEDIC LIMITATIONS

Please check any of the following conditions that you have or have had in the past:

_____ Osteoporosis	_____ Scoliosis
_____ Broken Bones	_____ Sprains/Strains
_____ Arthritis	_____ Balance/Walking Problems
_____ Fibromyalgia	_____ Limited Range of Motion
_____ Slipped/Ruptured Disc	_____ Subluxed/Dislocated Joints
_____ Weakness	_____ Painful Grinding/Cracking in a Joint
_____ Compression Fractures	

Have you had a recent: X-Ray____ MRI____ CT Scan____
If so, when? _____ _____ _____

Please list hospitalizations or surgeries you have had in the last five years, including dates:

_____

_____

Please list any medications you are currently taking:

_____

Are you allergic to any medications: Yes____ No____ If yes, please list: _____

Signature: _____ Date: _____
PT Signature: _____ Date: _____

Pure Physio
Physical Therapy

CONSENT TO TREATMENT FORM

1) **Informed consent for treatment:** I consent to and authorize Pure Physio Mobile Physical Therapy and its staff to administer physical therapy services. I understand and I am informed that, as in the practice of medicine, physical therapy may have some risks. I have the right to ask about these risks, inquire about my plan of care, and have all questions about my condition answered prior to treatment. I know it is my responsibility to inform the physical therapist/staff about my health condition, any health related changes, allergies, and medications.
2) **Cooperation with treatment:** I understand that in order for physical therapy services to be effective, I must come to scheduled appointments unless there are unusual circumstances. I agree to cooperate with the plan of care established by my physical therapist and also perform home exercises as instructed. If I have any concerns with my treatment plan, I will discuss it with my physical therapist immediately.
3) **Potential benefits and risks:** I may experience improvement in my symptoms and ability to perform daily activities. I may experience an increase in my current level of pain or discomfort. I may have some aggravation of my condition. This is usually temporary and if it does not subside in a reasonable time, I will contact my physical therapist.
4) **No warranty/guarantee:** I understand that my physical therapist uses evidence-based practice to help with my condition but there is no warranty or guarantee that my condition will improve. I understand that my physical therapist will review the plan of care, goals, and treatment options with me before I consent to treatment.
5) **Alternatives:** If I do not wish to continue physical therapy I will inform my physical therapist and have the ability to communicate alternative treatment options.
6) **Payment:** Payment must be provided prior to receiving treatment. I understand that I am fully responsible for charges not covered by insurance.
7) **Cancellation policy:** I understand that cancellations without a 24-hour notice may be charged a $50 cancellation fee. If a physical therapist attends my treatment location and I cannot participate in physical therapy, I may be responsible for the full treatment charge at a private pay rate. I understand that Pure Physio Mobile Physical Therapy schedules appointments one-on-one and my treatment time can be dedicated towards other patients with more than a 24-hour cancellation notice.
8) **Media Release:** I hereby grant to Pure Physio, P.C., the unlimited right and permission to use in perpetuity my photograph, video footage, actions, and/or testimonial, either alone or accompanied by other material, in any manner and in any media for any and all lawful purposes, including but not limited to, all promotion, marketing, advertising and publicizing of Pure Physio, P.C.

Print Name _____

Signature_____ Date_____

Pure Physio
Physical Therapy

CORONAVIRUS SCREENING AND LIABILITY RELEASE FORM

Due to the COVID-19 outbreak we are taking extra precautions with the intake of each client, health history review, as well as sanitation and disinfection practices. Please complete the following and sign below.

Symptoms of COVID-19 include:

-fever of 100 degrees or more - chills
-fatigue - muscle aches
-dry cough - new loss of taste or smell
-difficulty breathing - new rash or skin lesion

I, _____ agree to the following:

- I understand the above symptoms and affirm that I, as well as all household members, do not currently have, nor have experienced the symptoms listed above within the last 14 days.
- I affirm that I, as well as all household members, have not been diagnosed with COVID-19 within the last 30 days.
- I affirm that I, as well as all household members, have not knowingly been exposed to anyone diagnosed with COVID-19 within the last 30 days.
- I affirm that I, as well as all household members, have not traveled outside of the country, or to any city that has been considered a “hot spot” for COVID-19 infections within the last 14 days.
- I understand that Pure Physio, P.C. is a business and cannot be held liable for any exposure to the virus or any other contagion caused by misinformation on this form or the health history provided by each client.

I understand that because this treatment involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved from receiving treatment at this time, I voluntarily agree to assume those risks, and I release and hold harmless Pure Physio, P.C. from any claims related thereto. I hereby give my consent to receive treatment.

Print Name _____

Signature_____ Date_____

Pure Physio
Physical Therapy

HIPAA Compliance Patient Consent Form

I, _____, authorize the release of information of _____, including the diagnosis, records, examination, and treatment rendered to above patient, ledger and billing, and claims information.

The information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone (Initial here) _____

Pure Physio Physical Therapy agrees to the same stipulations. This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages and Communication from our office

If we are unable to speak directly to you concerning matters pertaining to your care, please check one of the following preferences:

[ ] You may leave a detailed message

[ ] Please leave a message asking me to return your call

[ ] Other _____

The best phone number to reach me at is _____

Signed: _____ Date: _____

Pure Physio
Physical Therapy

DIRECT ACCESS

In New Jersey, patients are allowed to receive physical therapy services without a referral from other healthcare providers. This saves the patient time and money associated with making another appointment to get a PT prescription. Overall, direct access allows you to get the care you need immediately. Details regarding the direct access policy from the New Jersey Administrative Code is quoted below:

"REFERRAL OF PATIENTS AND CONSULTATION STANDARDS FOR LICENSED PHYSICAL THERAPISTS

a) A licensed physical therapist shall refer a patient to a health care professional licensed to practice dentistry, podiatry or medicine and surgery in this State, or other appropriate licensed health care professional:

1) When the licensed physical therapist during the examination, evaluation or intervention has reason to believe that physical therapy is contraindicated or symptoms or conditions are present that require services outside the scope of practice of the licensed physical therapist; or

2) When the patient has failed to demonstrate reasonable progress within 30 days of the date of the initial treatment.

b) Not more than 30 days from the date of initial treatment of functional limitation or pain, a licensed physical therapist shall inform the patient's licensed health care professional of record regarding the patient's plan of care. In the event there is no identified licensed health care professional of record, the licensed physical therapist shall recommend that the patient consult with a licensed health care professional of the patient's choice. In a school setting, the schedule of physical therapy services shall be reported to the child study team by the licensed physical therapist within 30 days of the date of initial treatment. "

Reference: https://www.njconsumeraffairs.gov/regulations/Chapter-39A-State-Board-of Physical-Therapy-Examiners.pdf

NOTE: Patient is ultimately responsible for any cost incurred while receiving PT care that was not covered by patient's insurance benefits.