10601 Pecan Park Blvd
#302, Suite A3
Austin, TX 78750
www.sunphystherapy.com

REGISTRATION FORM

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Birth date: / /	Age:
Street address/P.O. Box:	City:			State:	ZIP Code:
Home Phone: ( )	Business Phone: ( )	Cell Phone: ( )		Email:	
Preferred method of contact: ❑ Home Phone ❑ Cell Phone ❑ Business Phone ❑ Email				Employer:	
Referred by:					

INSURANCE INFORMATION

Name of insured:	Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other_____	Insured's Date of Birth:
Address (if different):		Phone no.:

Insured's Employer:	Employer address:
Primary insurance:	

Member ID:	Group #.:	Insurance Co. Phone: ( )	Co-payment: $

Name of secondary insurance (if applicable):	Subscriber's name:	Member ID:	Group #:

EMERGENCY CONTACT

Emergency Contact:	Relation to patient:	Phone:

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance company and assign directly to this office all insurance benefits, if any, otherwise payable for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the use of this signature on all insurance submissions.

_____ _____

Patient/Guardian signature *Date*

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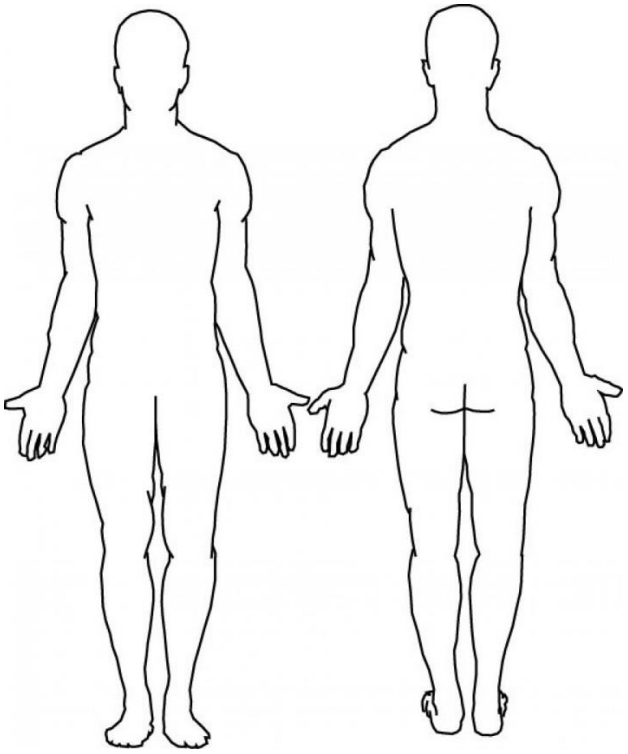
Medical questionnaire

Patient Name:	Date:
What problem or diagnosis brings in today?	
Briefly describe your symptoms:	
Describe how your condition or injury occurred:	

Shade the areas of pain or discomfort on the figures below:



Please rate your pain on a scale of 0 to 10

(0=no pain, 1-2/10=some discomfort, 5/10=moderate, 10/10=emergency room)

Pain level at rest:

Pain level with activity:

What is the frequency of your pain?

❑ Constant ❑ Intermittent

Does pain disrupt sleep?

❑ Yes ❑ No

How many times/night?

What eases your symptoms?	What aggravates your symptoms?
What activities are you unable to perform?	
Have you had any other treatment for this condition (Explain)?	
Have you had surgery for this injury?: ❑ Yes ❑ No	If yes, what was the surgery?

Date of Surgery:	Date of Injury:	Surgeon:

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Name:	Date:
Medications (please list): ❑ Vitamins ❑ Special Diet	
Current level of physical activity: ❑ High ❑ Medium ❑ Low List:	
What goals do you hope to accomplish with physical therapy?	
Do you now or have you ever had any of the following?	

	YES	NO		YES	NO
Asthma, Bronchitis, Emphysema			High Blood Pressure		
Anemia			Shortness of Breath/Chest Pain		
Heart Attack or Surgery			Diabetes		
Coronary Heart Disease or Angina			Thyroid Problems		
Gout			Cancer		
Dizziness or Fainting			Weakness		
Emotional/Psychological Problems			HIV/AIDS		
Hernia			Hepatitis		
Numbness or Tingling			Infectious Diseases		
Severe or Frequent Headaches			Bowel or Bladder Problems		
Osteoporosis			Vision or Hearing Difficulties		
Sleeping Problems			Stroke/TIA		
Blood Clot/Emboli			Epilepsy/Seizures		
Pacemaker			Arthritis/Joint Pain		
Varicose Veins			Fibromyalgia		
Are You Pregnant?			Stress		
Weight loss/gain			Anxiety		
Do You Smoke?			Hormone Imbalance		

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Sun Physical Therapy or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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NOTICE OF PRIVACY RIGHTS

I understand that as part of the provision of healthcare services Sun Physical Therapy creates and maintains health records and other information describing such information as my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested. By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment, and health care operations. I have the right to revoke this consent in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.

2. A photocopy or fax of this consent is as valid as this original.

3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment, or health care operations, be restricted. I also understand that the practice and I must agree to any restrictions in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon

Patient/Responsible Party Signature_____Date_____

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PHYSICAL THERAPY CONSENT FORM

Please read carefully, initial each statement, and sign on the line below.

____Consent: I consent to and authorize Sun Physical Therapy to administer physical therapy treatment under the direction and supervision of the physical therapist. I understand and am informed that, as in the practice of medicine, physical therapy may have some risks. I understand that I have the right to ask about these risks and have any questions about my conditions answered prior to treatment. I know it is up to me to inform the physical therapist/staff about any health problems or allergies I have, as well as medications I am taking.

____Minor Patients: The parent or guardian accompanying a minor is responsible for payment of services. Unaccompanied minors (under 18) will be denied non-emergency treatment, unless the parent or guardian has signed patient and financial responsibility forms.

____Release of Information: Sun Physical Therapy releases patient health care information for purposes of treatment or payment, or to other health care organizations, as explained in our HIPAA Notice of Privacy Practice. I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.

____No Guarantees: I understand that the practice of physical therapy is not an exact science and that no guarantees have been made to me as a result of treatments or examinations by the physical therapist or supportive staff. I understand that no contract, guarantee, warranty, or promise concerning the results of the physical therapy services is made.

____Collections: If your account becomes delinquent, collection proceedings will occur and you will be 100% liable for any collection fees, attorney and court costs incurred by Sun Physical Therapy to collect said fees from the Responsible Party.

____Returned Checks/Liens: Returned checks are subject to a $25.00 administrative charge as well as the bank's charge for bounced checks. Any liens will be subject to a $20.00 co-payment for each visit. In addition, the account will incur a 1.5% interest charge for balances >30 days.

____No Show/Cancel/Late Policy: Cancellations with less than 24 hrs notice will result in a $30.00 fee. Cancellations with less than 12 hrs notice, or no notice will result in a $45.00 fee. If you arrive late for your appointment, the therapist may not have the time to treat you or your therapy time may be reduced. The undersigned patient or Responsible Party acknowledges that he/she has read and agrees to the information listed above.

Patient/Responsible Party Signature_____Date_____