PATIENT REGISTRATION

Name:		**Today's Date:**	
Address:			DOB
City	State	Zip code	Age
Home#	Work #		Cell#
Email		Social Security #	
Emergency Contact		Relationship with Emergency Contact	
Phone # of Emergency Contact			
Patient's Employer		Patient's Occupation	
Reason for Today's Visit			
Referring Dr.		Phone#	
Primary care Dr.		Phone #	

Insurance Information

Private Insurance:		
Billing Address:		
Phone#	Subscriber	DOB:
ID#	Group#	

Car Accident:		
PIP insurance company	Claim#	Date of Accident
Billing address:	City	State
Adjuster:	Phone#	
Fax # of Adjuster	Email of Adjuster	

Work Related Injury: ◯ **Department of L&I** **or** ◯ **Worker's Comp/Self Insured**		
Date of Injury:	Claim#	Employer
Adjuster:	**Phone#**	
If self-insured, please provide billing address:		
Have you had Physical Therapy in the past related to this claim?	◯ **Yes**	◯ **No**

******* We Bill Primary Insurance Only***** *
I, the undersigned certify that I (or my dependent) have insurance coverage with the above listed insurance and hereby authorize you to evaluate and treat me (or my dependent) and I assign directly to GO PT, PLLC all medical benefits, if any, for services rendered. I authorize the release of all information necessary to secure payment of benefits. I authorize the release of medical and billing information to my referring physician or insurance company if requested.
Signature of insured/guardian: **Date:**

GOPT Medical History Questionnaire

Name: _____
Referring Provider: _____
Diagnosis: _____
Birthdate: _____Age:_____

What problem or complaint can we help you with today? _____
_____

Is this related to an injury or accident? Yes □ No □ Date of accident: _____
If yes, check which applies: Work □ Motor Vehicle □ Other (specify) □ _____
Are you currently off work because of this problem? Yes □ No □ Light Duty □
If yes, last day worked: _____ Occupation: _____
How and when did your symptoms start? _____Date: _____
Have you had this problem before? _____
What tests or treatment have you had for this problem? _____
Have you had any diagnostics? Xrays □ MRI □ Bone Scan □ CAT scan □ Nerve tests □ Blood tests □
Other□ Results: _____
Have you had surgery relating to this condition? Yes □ No □ Explain:_____Date:_____
List all medications you are currently taking for this or other problems: _____
_____

Currently, would you say your health is: Excellent □ Good □ Fair □ Poor □

Have you had any of the following:

Weakness □	Change in bowel/bladder □	Dropping things □
Numbness or tingling □	Pain with cough/sneeze □	Night pain □
Dizziness or nausea □	Blurred vision □	Unexplained weight loss □
Headaches □	Balance problems or Falls □	Fainting/drop attacks □

What is your pain intensity? (please circle below)

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

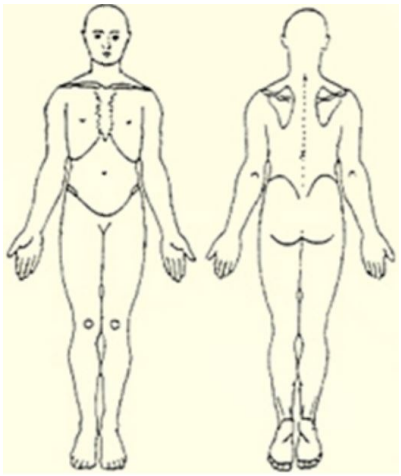
Which of these words describe your pain?
Sharp □ Dull □ Aching □ Burning □ Radiating □ Numb/tingling□
Constant □ Intermittent □ Buckling □ Locking □ Giving way □
Other □ _____

Do you have days or periods of time when you are completely pain free? Yes □ No □

How is your current condition progressing overall?
Improving □ Staying the same □ Getting worse □

What makes your problem (s) better?
Heat □ Ice □ Rest □ Medication □ Change in position □ Exercise □
Other □ _____

Please indicate your painful areas:



What makes your problem(s) worse?

Sitting □ Standing □ Walking□ Twisting □ Bending □ Squatting □ Stairs □
Rising from chair □ Pushing/pulling □ Kneeling □ Reaching □ Lifting □ Reclining □
Other □ _____

Are you able to continue your usual recreational activities? Yes □ No □ Limited □ (explain) _____
_____

Please list your usual exercise habits/sports/recreational activities: _____
_____

How many days per week do you exercise? _____ Average # minutes per day? _____
Have you had any falls in the past year? Yes □ No □
Are you currently pregnant? Yes □ No □ Not Applicable □
Have you had any of the following at any time in your life? Please circle.

Asthma	Diabetes	Arthritis	Headaches
Allergies	Bleeding disorder	Seizures	Anxiety
Lung problem	Polio	Broken bone	Depression
Heart disorder	Tuberculosis	Major Accident/Trauma	Connective tissue
High Blood Pressure	Osteoporosis	Whiplash	disorder
Lupus	Blood Clots/DVT	Sprain/Strain	Allergy to latex/adhesives
Stroke	Concussion	Nerve disorder	HIV/AIDS
Fibromyalgia	Cancer	Metal Implant	

Orthopedic Surgery: _____ Other Surgery: _____
Please explain any circled items: _____
_____

Any other conditions we should be aware of? _____

What are your goals that you are hoping to achieve with physical therapy? _____
_____

Consent for purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by GO PT for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of GO PT.

I understand that diagnosis or treatment of me by GO PT may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. GO PT is not required to agree to the restrictions that I may request. However, if GO PT agrees to a restriction that I request, the restriction is binding on GO PT.

I have the right to revoke this consent, in writing, at any time, except to the extent that GO PT has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that I have a right to review GO PT's notice of privacy practices prior to signing this document.

The GO PT Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of heatlh care operations of the GO PT.

This Notice of Privacy Practices also describes my rights and the duties of GO PT with respect to my protected health information.

GO PT reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by accessing the GO PT's web site, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

Billing Policy

If we are billing your insurance company please contact your insurance for the following information before your appointment with us.

Questions that need to be answered so that you know your outpatient physical therapy benefits are:

Our Employer Identification Number is **47-2453851**			
Outpatient Physical Therapy benefit %:			
Do you have a dollar/visit max per year?	◯ **Yes**	◯ **No**	Amount:
Do you have a deductible or copay?			
Is GO PT a provider with your insurance?			
Do you need a prescription or referral for PT?			

(Most insurance companies require a written prescription and/or authorization from your doctor, please be sure you have this with you or on file here.)

We are providers for the following insurance companies:

We also accept L&I and all workers Comp carriers. If your visit with us is Motor Vehicle Related we will only bill PIP coverage, we do not accept 3rd party claims. For privately insured patient's we will bill your primary insurance only. We expect payment within 60 days of the date of service by you or your insurance. We are not MEDICARE providers and cannot bill Medicare or supplemental coverage.

Payment for any co-pay's or supplies should be paid at the time of your visit. We accept cash, check, and most major credit cards. GO PT will charge a $25.00 NSF check fee if necessary.

CANCEL/NO SHOW POLICY

If you need to cancel or reschedule your appointment, we ask that you notify us via email or phone at least 24 hours before the start time of your appointment. Failure to do so will result in a $50.00 charge which is not payable by insurance.

This is a verification of your benefits as described by you insurance company, this is not a guarantee of payment. All payments are subject to the member's eligibility at the time the claim is processed. I understand that GO PT, PLCC will bill my insurance company directly, but that I am personally responsible for any copays, deductibles, or balances incurred. If my insurance company denies claims or my claims go to medical review I understand I am financially responsible for all services.

Signature Date