ProCare Therapy Services
Patient Registration Form

☐ Mr. ☐ Miss
☐ Mrs. ☐ Ms. Last Name _____ First: _____ M.I. _____
Social
Sex: ☐ M ☐ F Security # _____ Birth Date _____ Age _____

Patient Information: **Date:**

Address:	City:	State: Zip:
Phone – Home or Cell (Please circle):	Email:	Marital Status: (Circle) S / M / D / Sep / W/
Preferred method of contact:	Appointment Reminders (Circle One): Voice / Text / Email	
Occupation:	Employer:	Employer Phone:
Emergency Contact Name:	Relationship:	Phone:

Reason for Today's Visit

Date of Onset _____ _____ Chronic _____ New Injury _____ Accident _____ Work Related

Description of Problem _____

How did you hear of ProCare Therapy Services?_____

Who can we thank for referring you?_____

Referring Physician:

Name:	Address, City, State:	Phone:

Insurance Information:

Primary Insurance:	Group Number:	Policy (ID) Number:
Subscriber Name:	Subscriber Social Security Number:	Subscriber Birth Date:
Patient Relationship to Subscriber:	Co-Payment:	
Secondary Insurance:	Group Number:	Policy (ID) Number:
Subscriber Name:	Subscriber Social Security Number:	Subscriber Birth Date:
Patient Relationship to Subscriber:	Co-Payment:	

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

Patient Signature:_____ **Date:**_____

ProCare Therapy Services
Medical History Form

Name _____ DOB _____

Medical History: (please check any condition you have a history of. Items not checked are understood to be negative.)

___ High blood pressure	___ Abnormal bleeding	___ Bowel/bladder problems	___ Heart problem
___ Asthma	___ Autoimmune disorder	___ Recent/sudden weight loss/gain	___ Abnormal heart rate
___ Emphysema	___ Thyroid problem	___ Chronic lung problem	___ Pacemaker
___ Chronic heartburn	___ History of ulcers	___ Diabetes (med dependent Y/N)	___ Heart palpitations
___ Night sweats	___ Shortness of breath	___ High cholesterol	___ Angina (chest pain)
___ Seizures/epilepsy	___ Osteoporosis	___ Cancer/tumors (where?)	___ Arthritis
___ Dizziness	___ Hearing problems	Other: list here:	

Do you have history of fractures?	Yes	No	Where?	_____
Do you have a history of back/neck pain	Yes	No	When?	_____
Do you have any metal implants?	Yes	No	Where?	_____
Do you Smoke	Yes	No	How much/day?	_____
Do you exercise regularly?	Yes	No	How often?	_____
Do you have any known allergies	Yes	No	Please list	_____
Are you allergic to latex	Yes	No		
Are you pregnant or suspect pregnancy?	Yes	No		

Medications: Please check if you are taking any of the following (Please list names of medications)

___ Blood Pressure Medication _____		___ Heart medication _____	
___ Anti-Coagulants (blood thinners) _____		___ Muscle Relaxants _____	
___ Pain Killers _____		___ Diabetes Medication _____	
___ Steroids (cortisone) _____		___ Anti-Inflammatories _____	
___ Other			

Surgeries: : Please list all surgeries, including date:

Diagnostic Tests: Please check test(s) for current problem only:

___ X Rays	___ CT Scan	___ MRI	___ Bone Scan	___ EMG
___ Blood Chemistry	Ultrasound	Bone Density	Other	

Have you seen anyone else for your current problem?

___ Orthopedic Surgeon	___ Physician/MD	___ Podiatrist	___ Chiropractor	___ Dentist
___ Neurologist/Neurosurgeon	Osteopath/DO	Physical Therapist	Date	

Do you have these Symptoms: (In regards to your current condition)

"Pins & Needles" or numbness in your extremities?	Yes or No	Weakness in your arms or legs?	Yes or No
Coordination or Balance problems?	Yes or No	Difficulty Walking?	Yes or No
Dizziness or vertigo with a change in position?	Yes or No	Headaches as a result of your condition?	Yes or No

CHIEF COMPLAINT/CURRENT CONDITONS: Please describe:

Please rate your pain in this scale of 0-10:

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst pain imaginable

I believe all information above to be true and complete:

Patient Signature:_____ **Date:**_____

Therapist Signature:_____ **Date:**_____

ProCare Therapy Services
Office Policies and Procedures

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

We have developed this information to make you aware of our billing policies at the time of your initial office visit. Please review these policies carefully.

Primary Health Insurance: Skilled therapy services are reimbursed under the provisions of most health insurance policies. You, as the subscriber, are primarily responsible for knowing the terms of your policy. Our office personnel are familiar with various coverages offered by health insurance companies, and will assist you. If you (the subscriber) should receive a check from your insurance company that is intended for this practice (the provider) for services rendered, you should immediately remit this to our office for credit to your account. Failure to do so will result in our office billing you for the complete balance and you will be responsible for payment of this amount in full.

Liability/Legal: We do accept legal cases. Your health insurance plan and/or auto insurance with a medpay plan will be initially utilized. We will accept the insurance plan's allowable, along with the copays and/or deductibles, as payment in full for any covered services rendered to our patients. However, once the health insurance plan indicates that it will no longer pay for skilled therapy benefits the service will no longer be considered a covered service.

Worker's compensation patients will be accepted according to the Worker's Compensation Law enacted in 1992. Should your claim be denied by the R. I. Worker's Compensation Court, you will be responsible for providing us with your third party insurance so that therapy services rendered to you can be submitted for payment. If you do not have a third party insurance, please speak with the Billing Supervisor to make arrangements for payment of your account. Failure to attend skilled therapy may jeopardize your worker's compensation benefits.

Medicare: We will bill Medicare for you. In most cases, Medicare will pay 80% of allowable charges. We will also bill your secondary insurance for you, if you have one, or the balance will be billed to you and is payable at the time of the service rendered.

Medicaid does not pay for skilled therapy in an outpatient private practice.

If you are going to be late for your appointment, please call to inform us of your expected arrival time. Your appointment may need to be rescheduled at the discretion of the therapist, to ensure that your late arrival will not interfere with the treatment of patients scheduled after you.

Co-Payments are due at the time of service. Please contact the customer service department of your insurance company for the information regarding your outpatient therapy benefits, co-pay amounts and deductible amounts.

I, _____, fully understand the contents of ProCare Therapy Services office policies and procedures and agree to abide by them. I also understand and agree to pay for the charges that may be made towards my account for therapy services rendered by this office, consistent with the terms of my health insurance policy.

Signature _____ Date _____

ProCare Therapy Services
Missed Appointment and HIPAA Policies

PATIENT HIPPA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (Including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Name Printed	Signature	Date

MISSED APPOINTMENT POLICY

We want to thank you for choosing us as your health care provider. To give you and all of our patients the best possible care, we request that you review our policy regarding missed appointments.

A missed appointment is when you fail to show up for an allotted appointment time, without a phone call or cancellation notice of at least 24 hours. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24-hour notice to reschedule your appointment as this will enable us to offer your cancelled time to other patients.

If you are unable to keep your scheduled appointment time, please call our office at least 24-hours in advance to avoid a missed appointment fee. This charge is not covered by insurance. Your phone call is critical in helping us provide continuous care to all our valued patients. If you fail to give us notice of your missed appointment, you will be charged $25 missed appointment fee.

I have read and understand the policy stated above:

Patient Name Printed	Signature	Date