PATIENT REGISTRATION

Date: ____ /____ /____

NAME (LAST, FIRST, MIDDLE)				PREFERRED NAME
ADDRESS (STREET, APT#)		CITY, STATE		ZIP CODE
HOME PHONE	WORK PHONE		CELL PHONE	
SSN	SEX	EMAIL ADDRESS		DATE OF BIRTH / /
DATE OF INJURY / ONSET OF PROBLEM / /	ACCIDENT / INJURY OCCURRED ___ WORK ____SCHOOL ___AUTO ___OTHER (PLEASE LIST BELOW) ______________________________			
EMERGENCY CONTACT	PHONE NUMBER		RELATIONSHIP	
PRIMARY INSURANCE	POLICY/ ID NUMBER		GROUP NUMBER	
POLICYHOLDER NAME (LAST, FIRST, MIDDLE)				
SECONDARY INSURANCE	POLICY/ ID NUMBER		GROUP NUMBER	
POLICYHOLDER NAME (LAST, FIRST, MIDDLE)				

NO SHOW/ CANCELLATION POLICY

You are provided a specific time/date for physical therapy sessions. If you do not show or cancel at the last minute, we are unable to fill with another patient. We ask that you provide a 24 hour notice for appointment cancellation. If you do not cancel within 24 hours, you will be charged a fee for the missed appointment. Fees are listed below.

1. Regular Therapy Appointment $25.00 2. Women's Health $50.00 3. Pool Therapy Appointment $50.00

I certify that this information is true and correct to the best of my knowledge. If there are any changes to any of this information it is my responsibility to inform Palmetto Rehabilitation Specialists. Please ask the front desk for our self pay rates if you do not have health insurance.

____

Signature of Person Financially Responsible Date Accepted By

____

Guarantor's Signature (if patient is a minor) Date

PALMETTO REHAB
PHYSICAL THERAPY

PAST MEDICAL HISTORY

Weight: ______ **Height:** ______ **Date:** _____ /_____ /_____

Please check if you have a history of or are currently having issues with any of the following:

☐ ADD/ADHD	☐ Dizziness	☐ Multiple sclerosis	☐ Pacemaker
☐ Allergies	☐ Epilepsy/ Seizures	☐ Headaches/Migraines	☐ Parkinson's Disease
☐ Asthma	☐ Gall Bladder Problems	☐ Hypertension (High BP)	☐ Psychiatric History
☐ Arthritis	☐ Gastrointestinal (ulcers)	☐ Hypotension (Low BP)	☐ Skin Disease
☐ Cancer	☐ Hepatitis, Jaundice	☐ Kidney/ Urinary	☐ Tuberculosis
☐ Diabetes	☐ Heart Disease	☐ Respiratory (Emphysema)	☐ Vascular Problems

☐ Other Explain: ____

BODY CHART

Please mark the location of your pain and the type of pain on the chart:

Key:

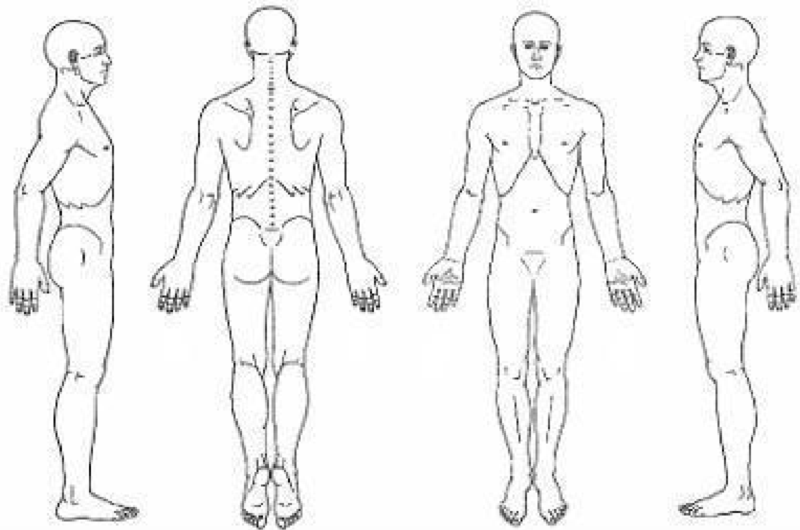
X Sharp stabbing pain

O Dull achy pain

... Numb/tingly pain

/// Throbbing

^^^ Burning



Pain Currently:	no pain 0 1 2 3 4 5 6 7 8 9 10	Worst imaginable pain
Pain at Lowest:	no pain 0 1 2 3 4 5 6 7 8 9 10	Worst imaginable pain
Pain at Worst:	no pain 0 1 2 3 4 5 6 7 8 9 10	Worst imaginable pain

Have you fallen within the last year? ☐ YES ☐ NO

If yes, how many times? __________________

Was an injury sustained during the fall? ☐ YES ☐ NO

What caused the fall(s)? _____________________________
____

Have you had any of the following services this year?

☐ Physical Therapy ☐ Occupational Therapy

☐ Chiropractic ☐ Home Health

Please list major surgeries/illnesses/hospitalizations with the last 10 years:

____
____
____

Please list all current medications with dosages and reason for medication (attach separately if not enough space):

☐ *list attached separately*

____
____
____
____

Guarantor's Signature:_______________________________
Patient Signature:___________________________________

PATIENT INFORMATION ACKNOWLEDGEMENT Date: ____/____/____

DESIGNATED AUTHORIZATION

Patient Name:____ DOB:_________________

Patient Information Acknowledgement:

I have reviewed and fully understand Palmetto Rehabilitation Specialists' *Notice of Information Practices and Patient's Rights*. The notice is posted in the reception area of each clinic and can also be provided to me on the patient portal. I understand that PRS may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any additional administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal information is used and disclosed if I notify the practice in writing.

Consent of Treatment & Authorization to Release Information:

I hereby authorize PRS (through the appropriate personnel) to perform, or have performed upon me, or the above named patient, appropriate assessment and treatment procedures. I further authorize PRS to release any information acquired in the course of my, or the above named patient's examination and treatment, to the appropriate agencies.

Designated Individuals Authorization:

There may be times when it is necessary for an individual, other than yourself, to need access to your medical information. In order for that information to be released you must grant them authorization by listing their name and relationship in the designated space below. There will be no circumstance where your medical information is released, other than to appropriate agencies, without your written permission.

If you do not agree to grant access to anyone other than yourself and the appropriate agencies, please mark NONE. If you do wish to grant authorization to certain individuals, please fill in the information below.

Authorized Individuals:

_____NONE

Name:____ Relationship:______________________________________

Name:____ Relationship:______________________________________

Name:____ Relationship:______________________________________

Name:____ Relationship:______________________________________

I hereby authorize the designated parties above to request/receive my protected health information which includes, but is not limited to, treatment notes, billing/payment records and any other administrative records related to my treatment. I understand that the identity of the designated parties will be verified before any information is released. I also acknowledge that any changes to this form must be made in person and in writing. I consent to the use and disclosure of my personal health information as note in the *Notice of Information Practices*. I understand that I retain the right to revoke this consent at any time by notifying PRS staff in writing.

Patient Signature:____ Date:_____________________________

Guarantor's Signature (if patient is a minor):____