

**Amber Hill Physical Therapy  
Registration Form**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ Social Security Number \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Email address \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Emergency Phone (\_\_\_\_) \_\_\_\_\_

Referring Physician \_\_\_\_\_ Doctor's Phone (\_\_\_\_) \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ PCP Phone (\_\_\_\_) \_\_\_\_\_

Diagnosis \_\_\_\_\_ Date of Onset/Injury \_\_\_\_\_

Have you had prior therapy? No Yes For what condition? \_\_\_\_\_

Is this problem related to a motor vehicle accident or work related injury? No Yes

If you answered yes to the above, please complete the following insurance information:

PIP or Worker's Compensation Carrier \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Adjustor's Name \_\_\_\_\_ Claim Number \_\_\_\_\_

Claims Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

**Insurance Information**

Primary Insurance \_\_\_\_\_ Policy Number \_\_\_\_\_

Policy Holder \_\_\_\_\_ Policy Holder's SSN \_\_\_\_\_

Policy Holder's Date of Birth \_\_\_\_\_

---

Secondary Insurance \_\_\_\_\_ Policy Number \_\_\_\_\_

Policy Holder \_\_\_\_\_ Policy Holder's SSN \_\_\_\_\_

Policy Holder's Date of Birth \_\_\_\_\_

**Guarantor Information (Please complete if patient is under 18.)**

Guarantor Name \_\_\_\_\_ Guarantor Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

Guarantor's SSN \_\_\_\_\_

**Please complete the following section regarding your current condition.**

1. Please describe injury/surgery and how the current episode began.

---

---

---

Onset date of current condition: \_\_\_\_\_

Have you had surgery for the current injury? Yes      No

Surgery Date: \_\_\_\_\_

2. Please list all physicians and healthcare providers you are seeing for this condition.

---

---

3. History of Pain: Please circle the number corresponding with your level of pain.

**Current pain level**

(Best) 0   1   2   3   4   5   6   7   8   9   10 (Worst)

**Worst pain level in the last week**

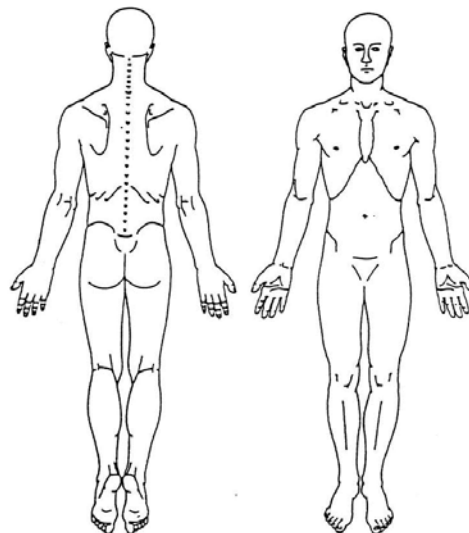
(Best) 0   1   2   3   4   5   6   7   8   9   10 (Worst)

**Best pain level in the last week**

(Best) 0   1   2   3   4   5   6   7   8   9   10 (Worst)

4. Description of Pain: Please mark the location of your pain on the drawing and describe by circling all of the following that apply:

Burning, Shooting, Achy, Sharp, Stabbing, Constant, Intermittent, Throbbing



5. Have you been previously treated for this condition? If so, please describe previous treatment and date(s).

---

---

---

6. What is your occupation? \_\_\_\_\_

Are you working at light or full duty? \_\_\_\_\_

If you are not working due to injury, when was the last date you worked? \_\_\_\_\_

7. Does your current injury/illness limit you in the following activities?

	Not Limited	Difficult	Unable to perform		Not Limited	Difficult	Unable to perform
Sitting				Sleeping			
Standing				Flight of Stairs			
Standing up from sitting				Managing Children			
Walking				Preparing Food			
Rolling in bed				Squatting down			
Driving				Shopping			
Reaching				Lifting			
Stooping				Carrying			
Dressing				Walking Distances			

**Please complete the following section regarding your overall health and past medical history.**

1. Are you being treated for any of the following conditions currently or have you in the past? (please circle)

- |                            |                           |                                 |
|----------------------------|---------------------------|---------------------------------|
| Allergies                  | Epilepsy/Seizures         | Pregnant (currently)            |
| Arthritis (OA or RA)       | Fibromyalgia              | Problems sleeping/Pain at night |
| Asthma                     | Headaches                 | Recent weight loss              |
| Bowel/bladder changes      | Heart/Circulatory Disease | Steroid use                     |
| Breathing Problems         | Hepatitis                 | Stroke/CVA                      |
| Cancer                     | High Blood Pressure       | Surgery                         |
| Dental conditions          | HIV/AIDS                  |                                 |
| Diabetes                   | Nausea/vomiting           |                                 |
| Dizziness/ lightheadedness | Pacemaker                 |                                 |

2. If you circled any of the above, please describe and provide dates.

---



---



---

3. Please list current medications.

---



---



---

4. Please rate your overall health at this time. (Please circle one)

Excellent                  Good                  Fair                  Poor

5. Have you fallen in the past 12months?                  Yes                  No

If yes, how many times have you fallen in the past 12months? \_\_\_\_\_

If you have fallen, have any of your falls resulted in injury?    Yes                  No

If your falls resulted in injury, please describe.

---



---



---

**Amber Hill Physical Therapy**

**Consent for Care and Treatment**

I, the undersigned, do hereby agree and give my consent for *Amber Hill Physical Therapy* to furnish medical care and treatment to \_\_\_\_\_ considered necessary and proper in diagnosing or treating his/her physical condition.

Patient/Guardian \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

**Benefit Assignment/Release of Information**

I hereby assign all medical benefits to which I am entitled, including private insurance and any other health plans, to *Amber Hill Physical Therapy*. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

Patient/Guardian \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

**Scheduling and Cancellation Policy**

**Amber Hill Physical Therapy reserves the right to bill a minimum \$35 no show fee for any appointment not canceled 24 hours in advance. Consistency in treatment is important to your rehabilitation outcome therefore multiple cancellations may result in termination of your treatment or a loss of prime (desired) schedule time.**

**If you are late for an appointment we may not be able to provide you with treatment as a courtesy to our other patients.**

Patient/Guardian \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

***Financial Policy Statement***

It is our policy to bill your insurance carrier as a courtesy to you, although you are responsible for the entire bill when the services are rendered. A payment of your estimated share is required to be paid upon each visit. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. If your carrier pays any funds in excess you will be refunded the credit. All patient balances over 60 days from date of transfer to patient responsibility, will be charged interest monthly at the rate of 10% annually. We reserve the right to discontinue treatment if no attempt to resolve large past due balances is made.

## Patient Responsibility

While being treated at Amber Hill Physical Therapy, there may be the need to use certain products to improve your treatment. **As the patient, you are responsible for providing these items. (Exp. Theraband, Electrical Stimulation Pads, Hand therapy products such as Coban, Stretch bandages, TubiGrip, Stockinette or supplies used for Splints)** You may provide these items yourself or you may purchase them from AHPT at a reduced price. These items are not considered durable medical equipment and the cost is not covered by your insurance company. You are responsible for the cost of any items purchased. AHPT will provide you with a receipt to submit to any Health Care Savings or Flex plans.

Patient or Responsible Party \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

## Patient Agreement

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by *Amber Hill Physical Therapy*, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

Estimated patient payment % \_\_\_\_\_

(Estimated coverage information is provided as a courtesy, but is not intended to release the patient from total responsibility for the account balance.)

Patient or Responsible Party \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

AHPT Representative \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

## Acknowledgement of Receipt of Notice of Privacy Practices

I, \_\_\_\_\_, have received the Notice of Privacy Practices from Amber Hill Physical Therapy Inc. The notice is dated April 14, 2003.

**Date:** \_\_\_\_\_

In lieu of patient signature, I, \_\_\_\_\_, a staff member of Amber Hill Physical Therapy Inc, state that

\_\_\_\_\_ has been given our current Notice of Privacy Practices.

**Date:** \_\_\_\_\_