

**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 \_\_\_\_\_

## Pediatric History/Parent Questionnaire

### **Prenatal History:**

Birth Weight \_\_\_\_\_ Height \_\_\_\_\_ Duration of Pregnancy \_\_\_\_\_

Type of Delivery: \_\_\_\_\_

Complications at birth:

\_\_\_\_\_

Treatment Received by baby and/or mother:

\_\_\_\_\_

Please list any injuries, illnesses, infections, hospitalizations, surgeries or other medical procedures your child has had and the ages these occurred:

\_\_\_\_\_

Does your child have any allergies? Please specify if allergy is triggered by contact or ingestion.

\_\_\_\_\_

Does your child have seizures or any other significant medical conditions?

\_\_\_\_\_

Current Medications:

\_\_\_\_\_

### **Developmental Milestones:** At what age did your child do the following?

Roll back to stomach \_\_\_\_\_ Roll stomach to back \_\_\_\_\_

Sit unsupported \_\_\_\_\_ Sit supported \_\_\_\_\_

Pull to stand \_\_\_\_\_ Crawl \_\_\_\_\_

Cruise \_\_\_\_\_ Walk \_\_\_\_\_

Climb stairs \_\_\_\_\_ Run \_\_\_\_\_

Begin eating solid foods \_\_\_\_\_ Finger feed self \_\_\_\_\_

Use utensils \_\_\_\_\_ Drink from cup \_\_\_\_\_

Living Arrangement (where, with whom, siblings, pets)

\_\_\_\_\_

How does your child spend their day? (Preschool, school, daycare, etc.)

\_\_\_\_\_

Please describe your concerns for this child?

\_\_\_\_\_

What does your child like/dislike?

\_\_\_\_\_

Is there anything else you would like us to know about your child?

\_\_\_\_\_

\_\_\_\_\_

**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 \_\_\_/\_\_\_/\_\_\_

**Cancellation Policy**

**\*Please refer to separate sheet for no show/cancellation policy and sign below for receipt.**

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