PT PROS
Physical Therapy & Sports Centers

Patient Registration

First _____ MI ____ Last Name _____ Date of Birth _____

Mailing Address _____

City _____ State _____ Zip _____

Telephone Numbers		OK To Call	Best Time To Call
Home	_____	☐	_____
Work	_____	☐	_____
Cell	_____	☐	_____

Social Security # _____ Gender ☐ Male ☐ Female

Email Address _____

Driver's Lic # _____ Issuing State _____

Marital Status
- ☐ Divorced
- ☐ Separated
- ☐ Married
- ☐ Single
- ☐ Widowed
- ☐ Unknown

Employment Status
- ☐ Full-Time
- ☐ Part-Time
- ☐ Self Employed
- ☐ Active Military
- ☐ Retired
- ☐ None

Student Status
- ☐ Full-Time
- ☐ Part-Time
- ☐ None

Patient's Employer _____

Address _____

_____

Phone _____

Occupation _____

We are dedicated to improve the quality of every life we touch...

Spouse's Name _____

Employer _____

Address _____

_____

Phone _____

Occupation _____

Emergency Contact _____

Address _____

_____

Phone _____

Relation _____

Family Physician _____

Primary Insurance _____ Phone _____

Address _____ Effective Date _____

_____ ID # _____

If Auto Insrance, Name of Insured _____ Group # _____

Subscriber's Name _____ Patient's Relation to Subscriber _____

Social Security # _____ Date of Birth _____ Gender ☐ Male ☐ Female

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Secondary Insurance _____ **Phone** _____

Address _____ **Effective Date** _____

_____ **ID #** _____

If Auto Insurance, Name of Insured _____ **Group #** _____

Subscriber's Name _____ **Patient's Relation to Subscriber** _____

Social Security # _____ **Date of Birth** _____ **Gender** ☐ **Male** ☐ **Female**

Was this injury/accident related to: ☐ **Sports** ☐ **Work** ☐ **Automobile** ☐ **School** ☐ **Other** _____

Name of School or Employer at the time of Injury _____ **Date of Injury** _____

Attorney's Name (if applicable) _____ **Phone** _____

Preferred language _____ **Intepreter required?** ☐

How were you referred? (Please select only one)

- ☐ **Attorney**
- ☐ **Billboard**
- ☐ **Case Manager**
- ☐ **Email/Letter**
- ☐ **Employer**
- ☐ **Friend**
- ☐ **Newspaper**
- ☐ **Physician**
- ☐ **Radio**
- ☐ **Self**
- ☐ **Television**
- ☐ **Theater**
- ☐ **Website/Internet**

I authorize insurance benefits to be paid directly to PT PROS Physical Therapy and Sports Centers (PT PROS) and also authorize release of any or all medical records to my insurance company and its agents including rehabilitation coordinators. Further, I authorize PT PROS to obtain needed information from my physician, employer or insurance company and initiate any necessary insurance appeals. By signing below, I am also authorizing PT PROS to treat the above referenced patient and verify that I am said patient or the parent or legal guardian thereof.

NOTICE: By signing this agreement I acknowledge and understand that an interest charge of 1.5% per month will automatically be added to any unpaid balance each month. Furthermore, I understand and agree that if PT PROS is forced to take legal action to collect any part of my account which remains unpaid, I agree that I am responsible for any and all legal fees, including but not limited to attorney fees, which PT PROS incurs as a result of collecting such an account. I understand that I am responsible for any remaining balance owed to PT PROS.

X _____ Date _____

Patient Signature (Parent or Guardian if minor)

We at PT Pros realize that you have a choice with your therapy care and appreciate the opportunity to meet any expectations of care you may have. If at any time, you have questions, concerns, or suggestions please contact our Director of Patient Care at (606) 526-2210.

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Medical History

Area of Symptoms: _____

Date of Onset: _____ Age: _____

Please take a moment to complete the questions below. Depending on your answers, we may modify our treatment procedures for their effectiveness and your safety. Thank you.

Any known results of recent x-rays or tests: _____

_____

Chronic Conditions: Yes ☐ No ☐ If yes, please list: _____

_____

Allergies: Seasonal? ☐ Latex? ☐ Medications? ☐ Other? ☐ Please list: _____

_____

List surgeries and dates: _____

Medications: Yes ☐ No ☐ If yes, please list: _____

_____

Have you ever had treatment for this injury before? Yes ☐ No ☐ If yes, please specify: _____

_____

How do you sleep at night? Please check all that apply:

Difficulty falling asleep ☐ Difficulty finding a comfortable position ☐ Awaken by pain ☐

Other, please specify: _____

Do you have or have you had any of the following:

Cancer	Yes ☐	No ☐	High Blood Pressure	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Metal Implants	Yes ☐	No ☐
Epilepsy or Seizures	Yes ☐	No ☐	Respiratory Problems	Yes ☐	No ☐
Heart Disease	Yes ☐	No ☐	Arthritis	Yes ☐	No ☐
Pacemaker	Yes ☐	No ☐	Are you pregnant?	Yes ☐	No ☐

In the past 3 months, have you had or do you experience:

A change in your health	Yes ☐	No ☐	Changes in bowel or bladder function	Yes ☐	No ☐
Nausea/Vomiting	Yes ☐	No ☐	Shortness of breath	Yes ☐	No ☐
Fever/Chills/Sweats	Yes ☐	No ☐	Dizziness	Yes ☐	No ☐
Unexplained weight change	Yes ☐	No ☐	Upper Respiratory Infection	Yes ☐	No ☐
Numbness or tingling	Yes ☐	No ☐	Urinary Tract Infection	Yes ☐	No ☐
Changes in appetite	Yes ☐	No ☐			
Difficulty swallowing	Yes ☐	No ☐			

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Personal Representative Authorization

Member Name: _____

Section A - Purpose

This form allows you (the "Individual") to give PT PROS, Inc. permission (authorization) to disclose your protected health information (PHI) to a person that will act as your Personal Representative. The information covered by this authorization is protected health information, including identification of treating providers of care; diagnoses; procedures; and personal information, such as your date of birth and mailing address.
Each adult family member, including each adult child (age 18 or older, or as determined by state law), who wishes to name a Personal Representative must complete an authorization form. For example, if you expect your spouse to call us on your behalf, you need to fill out this form. If you do not wish to name a Personal Representative, do not complete this form. You are not required to name a Personal Representative, but if you do not, we will not release your protected health information to someone who may call or write on your behalf. Your Personal Representative maybe anyone of your choosing, such as a spouse, parent, child, friend, congressman or Union representative. You must provide the information requested in Section C for each person before we can treat that person as your Personal Representative. If you need additional forms, you may copy this form, or call us.
Please note: This authorization does not give your Personal Representative authority, either implied or direct, over any treatment of direct care decisions. Also, we will not condition enrollment, eligibility for benefits, or benefits payments on your completion of this form.

Section B - Individual's Information

I authorize PT PROS, Inc. to treat the person(s) named in Section C as my Personal Representative(s), subject to the rights and restrictions, if any, described in Section C.

My Name	*Date of Birth*	*Daytime Phone*	*Relationship to Member*

Section C - Authorized Use and/or Disclosure

I understand that the PT PROS, Inc.'s privacy practice is to not disclose my personal health information, except for the purpose of treatment, payment, and health care operations, or as required by law, without my written authorization. For this reason, I authorize you to disclose my protected health information to the person(s) named in Section C for the purpose of assisting with or facilitating the payment of my health plan benefits. Unless I have stated otherwise in Restrictions, I also allow my Personal Representative for the following rights: the right to request amendment of my PHI; the right to request an accounting of disclosures of my PHI; and the right to request restrictions on disclosure of my PHI.
I understand that if my Personal Representative is not a health plan, a health care provider or another entity subject to federal or applicable state privacy laws, those laws may no longer protect my personal health information, and my Personal Representative may further disclose my protected health information without my authorization. I acknowledge that my authorization is voluntary.
I understand that I have the right to limit the information you release under this authorization. For example, I may limit a Personal Representative's access to information only about a particular provider or diagnosis/disease; or I may allow a Personal Representative access to everything except information from a particular provider or about a particular diagnosis/disease. Any such limitations must be described in Restrictions, in this section.

Personal Representative #1

Full Name (please print)	*Phone Number*	*Relationship to You (such as: spouse, parent, child. friend)*	*Restrictions*

Personal Representative #2

Full Name (please print)	*Phone Number*	*Relationship to You (such as: spouse, parent, child. friend)*	*Restrictions*

Section D - Revocation

I understand that I have the right to revoke or end this authorization at any time. I understand that, if I do not wish any person named in Section C to remain my Personal Representative, I must revoke my authorization by giving written notice of my decision to the Privacy Official at the address shown below. I understand that my revocation of this authorization will not affect any action that you have taken or information that you have already released, based upon the authorization, before you receive my request to revoke authorization.

PT Pros, Inc. 383 Corbin Center Drive Corbin, KY 40702

Section E - Signature/Authorization

I, _____, have had full opportunity to read and consider the content of this form.
I understand that by signing this form, I am confirming my authorization that PT PROS, Inc. may disclose my protected health information to the person(s) named on this form, for the purpose described above.

Signature: _____ Date: _____

Please complete and sign this form, and return it to our Office Manager. You are entitled to a copy of this completed form.

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Acknowledegement of Receipt of Notice of Privacy Practices

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

X _____ Date _____

Patient Signature (Parent or guardian if minor)

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other (Please provide specific details)

_____

_____

X _____ Date _____

Employee signature