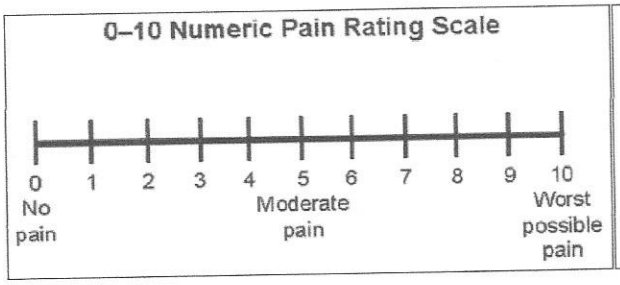
The following is required by insurance.

Patient Name:_____

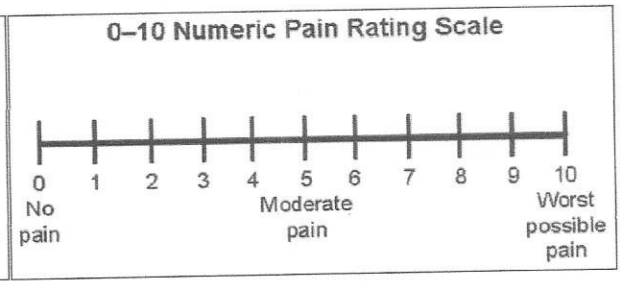
Current prescriptions, over the counter, herbal, vitamin, or dietary supplements:

Drug/Supplement Name:	Dosage:	Frequency:	Route: (oral, injection, suppository)

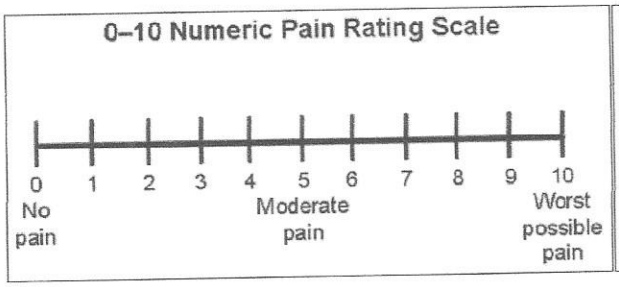
Circle your worst pain:



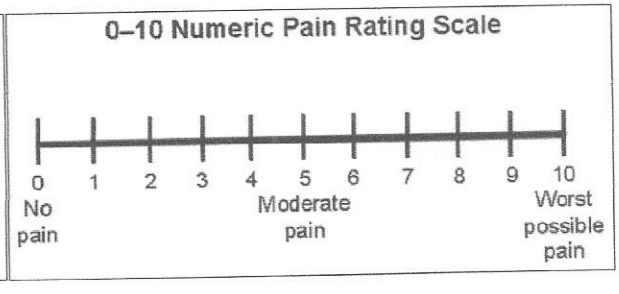
In the past 24 hours-Circle the least pain:



In the past 24 hours-Circle the most pain:



Circle your pain rating now:



OFFICE USE ONLY:

Height:_____ Weight:_____

Functional Outcome Test Completed:_____

PTI
PHYSICAL THERAPY
INSTITUTE

Patient Registration

(Please print)

Today's Date: _____

Patient's Name: _____

Please list your name exactly how it reads on your insurance card

DOB: _____ **SSN:** _____

Email Address: _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Primary Contact Number: (____) _____
Home Cell Work

Secondary Contact Number: (____) _____
Home Cell Work

Emergency Contact: _____ (____) _____
(Name) (Phone number)

Responsible Party (if patient is a minor): _____

Primary:
Insurance Carrier Name: _____

ID: _____ **Group #:** _____

Subscriber: Self or _____

If different than above, complete the following:
Subscriber's Address: _____

Subscriber DOB: _____ **Subscriber SSN:** _____

Secondary:
Insurance Carrier Name: _____

ID: _____ **Group #:** _____

Subscriber: Self or _____

If different than above, complete the following:
Subscriber's Address: _____

Subscriber DOB: _____ **Subscriber SSN:** _____

Signature: _____

I understand & agree that regardless of the insurance status, I am responsible for the balance on this account for any services rendered. I certify that all the above information is true and correct. I give Physical Therapy Institute consent to provide medical care to properly diagnose and treat my physical condition. I understand it is my responsibility to notify Physical Therapy Institute of any changes in the above information. By not signing, I am agreeing to remit payment in full for all services provided by the staff.

PTI
PHYSICAL THERAPY
INSTITUTE

Physical Therapy Institute
HIPAA Authorization Form
(Please print)

Today's Date: _____

Patient DOB: _____

I, _____ **have read the Physical Therapy**
(Patient's Name)
Institute Notice of Privacy Practices. A copy is available upon request.

I authorize Physical Therapy Institute to disclose my PHI (Protected Health Information) to the following providers and (or) facilities in regards to my treatment.

Medical Providers or Facilities:

Name: _____ **City:** _____

Name: _____ **City:** _____

Name: _____ **City:** _____

Name: _____ **City:** _____
(If you do not authorize the release of your information leave the above blank and sign below)

I authorize Physical Therapy Institute to disclose my PHI (Protected Health Information) to any person(s) indicated below. This would include family, friends, guardian, POA……

Name: _____ **Phone:** _____

Name: _____ **Phone:** _____

Name: _____ **Phone:** _____
(If you do not authorize the release of your information leave the above blank and sign below)

Signature: _____
By signing I certify that all the above is true & correct. I understand I have the right to revoke this authorization at any time and that it is my responsibility to request a new HIPAA form to make changes should any occur.

PTI
PHYSICAL THERAPY INSTITUTE

PATIENT MEDICAL HISTORY

Name: _____

Referring Physician: _____

Family Physician: _____

Date of First Doctor Visit for this Injury: _____

Is an Attorney Involved in this Case / Who: _____

Is this injury due to a motor vehicle accident: ☐Y ☐N If yes, what is the date of injury:_____

Have you had Surgery? ☐Y ☐N What Type/When: _____

Previous Treatment for this injury including diagnostic testing (ex: MRI or Xray):

_____

_____

Past Medical History relevant to this injury/episode:_____

_____

_____

_____

General Medical History (Current pathologies or diagnoses): _____

_____

_____

_____

List any other information that would assist us in your care: _____

_____

_____

Are you aware of your diagnosis and prognosis as explained by your doctor? ☐Y ☐N

What are your rehabilitation expectations/goals while in this program?

_____

_____

_____ _____

Patient/Guardian Signature Date