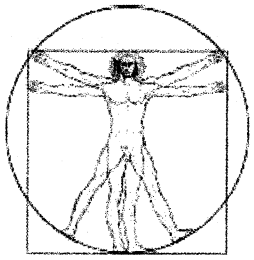


Integrity Physical Therapy

720 Chestnut Street
Bowling Green, Kentucky 42101

Patient Registration Form

Personal Information

Name:		Name you prefer:
Home Address:		Apt #
City:	State:	Zip Code:
Mailing Address:		
City:	State:	Zip Code:
Injury/ Diagnosis:		Home Phone:
Date of Injury/Onset of symptoms:		Work Phone:
Date of Birth:	Age:	Cell Phone:
Email Address:		
Emergency Contact:		Emergency Contact Phone #:
How did you hear about us?:		

Referring Physician Name:	Phone #:
City, State:	
Primary Care Physician Name:	Phone #:
City, State:	
Employer Name:	Occupation:
Address:	City, State:
Social Security Number (For Insurance Benefit Verification):	

Primary Insurance Information

Is this an auto accident?: Yes No	Is this a worker's comp case?: Yes No
If "Yes", list claim # and adjuster contact information:	
Health Insurance Company Name:	
Subscriber's Name:	Subscriber's Date of Birth:
Relationship to the Subscriber:	
Subscriber's Address and Phone # if different from patient:	
Address:	
City, State	Zip Phone#

Secondary Health Insurance Information

Health Insurance Company Name:		
Subscriber's Name:	Subscriber's Date of Birth:	
Relationship to the Subscriber:		
Subscriber's Address and Phone # if different from patient:		
Address:		
City, State	Zip	Phone#

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO HEALTH PROVIDER

Insurance Company/Companies Name(s) _____

I hereby instruct the above named insurance company/companies to pay by check made out to and mailed directly to: ***Integrity Physical Therapy*** for professional/medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY**. This payment will not exceed my indebtedness to the above mentioned assignee and I agree to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment as required by my insurance policy.

Patient Signature	Printed Name	Date
Parent or Guardian Signature (if under 18)	Printed Name	Date

Notice of Privacy Practices

I hereby authorize that I am aware of my rights as it pertains to HIPAA and my Protected Health Information (PHI). Integrity Physical Therapy has offered me a copy of their Notice of Privacy Practices for my own records.

If there is anyone you would like to authorize the disclosure of your PHI, medical or billing, you may specifically name the party below and indicate what information you would like to disclose:

1. _____ ☐entire medical record ☐diagnosis & medical treatment ONLY ☐billing ONLY
2. _____ ☐entire medical record ☐diagnosis & medical treatment ONLY ☐billing ONLY

Patient Signature	Printed Name	Date
Parent or Guardian Signature (if under 18)	Printed Name	Date

Staff Witness Initials:_____

Missed Appointment Policy

We strive to provide our patients with excellent service and quality care. Our commitment to your well-being and health care is something that we at *Integrity Physical Therapy* take very seriously.

Your commitment to your physical therapy program is critical to your success. We will recommend treatment and set goals for you. In order to reach those goals you must do your part and your most important part is to make each and every appointment.

We will give you an appointment card to keep track of your appointments. If you should misplace this, please give us a call to review your appointment dates. We expect you to keep all your appointments; however should you need to cancel please note that we require a **24-hour notice**.

If you need to cancel please call our office and reschedule. If you do not cancel with a **24-hour notice** or if you do not show for an appointment **you will be charged $35** for the missed appointment.

If you miss **3** consecutive appointments we will notify your physician and will require a new referral in order to continue your treatment.

We thank you for choosing *Integrity Physical Therapy* and we are looking forward to working with you and helping you reach your goals.

The Staff at Integrity Physical Therapy

I have read and understand this policy.

_____ _____

Patient/ Guardian Date

Medical History Information Sheet

1. What would you say is the pain rating for your current condition using a scale of 0 – 10? (0=no pain, 10=worst pain imaginable) _____

2. Do you now or have you ever had the following?

		Explain
Stroke	*yes* _____ *no* _____	_____
Heart Disease or Heart Murmur	*yes* _____ *no* _____	_____
High Blood Pressure	*yes* _____ *no* _____	_____
Asthma	*yes* _____ *no* _____	_____
Diabetes	*yes* _____ *no* _____	_____
Epilepsy/Fainting	*yes* _____ *no* _____	_____
Impairment of Vision or Hearing	*yes* _____ *no* _____	_____
Cancer	*yes* _____ *no* _____	_____
Drug Allergies	*yes* _____ *no* _____	_____
Osteoporosis	*yes* _____ *no* _____	_____

Orthopaedic History – Please give dates & treatments received:

3. Have you ever sprained, strained, dislocated or fractured the following:

   Neck/Head (including concussion) _____

   Trunk (ribs, vertebrae, sternum) _____

   Low Back (vertebrae, discs, nerves) _____

   Upper Extremity (shoulder, elbow, wrist, arm) _____

   Lower Extremity (hip, leg, knee, ankle, foot) _____

4. Please list any surgeries that you have had and their dates:
   _____

5. Please list medication(s) presently taking: _____

6. Women: Are you pregnant? yes _____ no _____

7. Have you ever had PT in the past?_____
   If so, when? _____

8. **IF YOU HAVE MEDICARE, HAVE YOU EVER HAD HOME HEALTH CARE?**_____

9. If so, what is the **name and phone number** to the agency? _____

I agree that the above information accurately describes my medical history and that should any changes in my medical history occur, I will notify my PT immediately

Signature_____date:_____

Patient Health Questionnaire - PHQ

Form PHQ-202

rev 7/18/05

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

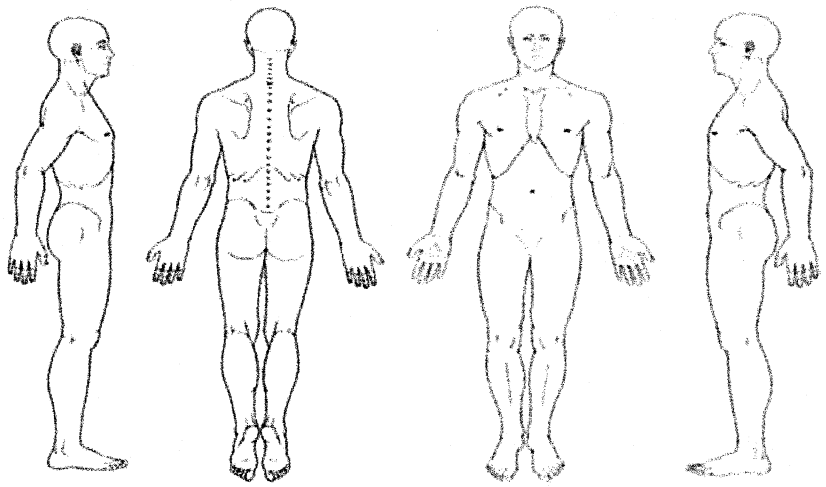
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ *Unbearable*

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No One
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature _____ **Date** _____

Please complete all requested information:

Have you ever had: If yes, please explain

High Blood Pressure	No O Yes O	_____
Heart or Circulation Disorders	No O Yes O	_____
Seizures	No O Yes O	_____
Dizzy Spells	No O Yes O	_____
Diabetes	No O Yes O	_____
Cancer	No O Yes O	_____
Arthritis/Osteoarthritis	No O Yes O	_____
Osteoporosis	No O Yes O	_____
Immune Deficiency Disease	No O Yes O	_____
Other	No O Yes O	_____

Do you have any METAL anywhere in your body; pins/plates post fracture, or pacemaker (other than teeth?

No O Yes O Describe: _____

***(For women only)* Are you now pregnant?** No O Yes O

Do you have any abnormal trouble with vision? No O Yes O ***Hearing?*** No O Yes O

List any allergies you have _____

List any medications you are now taking _____

_____

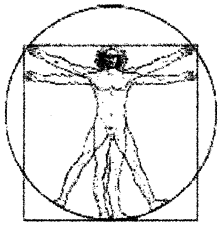
Have you ever had Physical Therapy treatments before? No O Yes O

If yes, please indicate where, when, and for what problem _____

_____

Date of last Doctor appointment: _____/_____/_____ **Date of next appointment** _____/_____/_____

For office use ONLY:



Integrity Physical Therapy

720 Chestnut Street
Bowling Green, Kentucky 42101

Patient Information Consent Form

I have read and fully understand Integrity Physical Therapy Notice of Information Practices. I understand that Integrity Physical Therapy **Inc.** 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 administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Integrity Physical Therapy, will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Integrity Physical Therapy Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____
Patient Name

_____
Signature

_____
Date