STAY FIT
Physical Therapy & Core Wellness, Inc.™
GET FIT • STAY FIT

NEW PATIENT REGISTRATION

PLEASE PRINT

PATIENT INFORMATION

THERAPIST	APPOINTMENT DATE: _______/_______/_______

LAST NAME	FIRST NAME	MI	DOB	SOCIAL SECURITY	SEX

MARITAL STATUS Single () Married () Other ()	Have you been treated at Stay Fit Physical Therapy clinic before? If yes, when?	EMAIL ADDRESS

EMPLOYMENT STATUS Employed () Student: FT () PT ()	EMPLOYER/SCHOOL NAME	TITLE/POSITION

HOME ADDRESS CITY	STATE	ZIP CODE	DAYTIME PHONE	CELL PHONE

REFERRING PHYSICIAN INFORMATION

LAST NAME	FIRST NAME	ADDRESS	PHONE

REASON FOR YOUR VISIT TODAY

WHAT NUTRITION/HEALTH GOALS DO YOU WISH TO ACCOMPLISH BY SEEING A REGISTERED DIETITIAN (RD)?

WHO RECOMMEND YOU SEE A REGISTERED DIETITIAN?	HOW DID YOU HEAR ABOUT NUTRITION SERVICES OFFERED AT STAYFIT?
RATE YOUR CURRENT NUTRITION KNOWLEDGE 1=POOR 5=EXPERT 1 2 3 4 5	

HOW READY ARE YOU TO MAKE LIFESTYLE CHANGES ON A SCALE OF 1-5 (1=NOT READY, 5=VERY READY)? 1 2 3 4 5

PRIMARY INSURANCE COMPANY INFORMATION

PRIMARY INSURANCE COMPANY NAME	IDENTIFICATION NUMBER	GROUP NUMBER	
ADDRESS OF PRIMARY INSURANCE	CITY	STATE	ZIP CODE
POLICYHOLDER NAME (IF DIFFERENT FROM PATIENT)	PHONE NUMBER OF POLICY HOLDER	RELATIONSHIP TO PATIENT	

SOCIAL SECURITY (POLICYHOLDER'S)	DOB (POLICYHOLDER'S)	RELATIONSHIP TO PATIENT
EMPLOYER (POLICYHOLDER'S)	HOME PHONE	CELL PHONE

SECONDARY INSURANCE COMPANY INFORMATION

SECONDARY INSURANCE COMPANY NAME	IDENTIFICATION NUMBER	GROUP NUMBER	
ADDRESS OF SECONDARY INSURANCE	CITY	STATE	ZIP CODE
POLICYHOLDER NAME (IF DIFFERENT FROM PATIENT)	PHONE NUMBER OF POLICY HOLDER	RELATIONSHIP TO PATIENT	

SOCIAL SECURITY (POLICYHOLDER'S)	PHONE (POLICYHOLDER'S)	RELATIONSHIP TO PATIENT

EMPLOYER (POLICYHOLDER'S)	WORK PHONE (POLICYHOLDER'S)

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IN CASE OF EMERGENCY

LAST NAME	FIRST NAME	MI

ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	DAYTIME PHONE	CELL PHONE

RELATIONSHIP	EMAIL ADDRESS

FINANCIAL POLICY

> I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY THE INSURANCE COMPANY(S) LISTED ON THIS REGISTRATION. I UNDERSTAND THAT VERIFICATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT OR A GUARANTEE OF PAYMENT ACCORDING TO THE ACTUAL BENEFITS QUOTED. SHOULD I NEED DETAILED INFORMATION ABOUT MY COVERAGE, I WILL CONTACT MY INSURANCE COMPANY DIRECTLY.

> IN THE EVENT MY ACCOUNT BECOMES DELINQUENT, AND IS THEREFORE IN DEFAULT OF PAYMENT, I ACCEPT RESPONSIBILITY FOR THE PRINCIPLE AMOUNT OWING AS WELL AS ALL REASONABLE COSTS AND ADDITIONAL LEGAL FEES ASSOCIATED WITH THE RECOVERY OF THIS DEBT.

> SHOULD MY INSURANCE COMPANY ISSUE A DENIAL OF PAYMENT, AND I CHOOSE TO CONTINUE WITH STAY FIT PHYSICAL THERAPY & CORE WELLNESS, INC., I AGREE TO MAKE PAYMENTS AT THE TIME ALL SUBSEQUENT SERVICES ARE PROVIDED.

> I UNDERSTAND THAT THIRD PARTY BILLING TO ATTORNIES OR THIRD PARTY MOTOR VEHICLE CARRIERS IS NOT AVAILABLE.

> I AGREE TO BE RESPONSIBLE FOR INSURANCE DEDUCTABLES, CO-PAYMENTS, CO-INSURANCE, AND SUPPLY FEES AT THE TIME SERVICES ARE RENDERED.

> INTEREST MAY BE CHARGED AT A RATE OF 1.5% PER MONTH (18% ANNUALLY) FOR UNPAID BALANCES OVER 30 DAYS OLD.

> I UNDERSTAND THAT A FEE OF $40.00 WILL BE ASSESSED FOR ANY CHECK RETURNED UNPAID.

> WE ACCEPT CASH, CHECKS, VISA AND MASTERCARD

ASSIGNMENT OF BENEFITS / AUTHORIZATION TO RELEASE MEDICAL INFORMATION / CONSENT OF TREATMENT

I HEREBY ASSIGN ALL MEDICAL BENEFITS TO WHICH I AM ENTITLED TO STAY FIT PHYSICAL THERAPY & CORE WELLNESS, INC. I HEREBY AUTHORIZE STAY FIT PHYSICAL THERAPY & CORE WELLNESS, INC. TO RELEASE ANY INFORMATION NECESSARY TO SECURE THE PAYMENT OF SAID BENEFITS. A COPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. THIS CONSENT IS INTENDED AS A WAIVER OF LIABILITY FOR SUCH TREATMENT EXCEPTING ACTS OF NEGLIGENCE.

CANCELLATION / NO SHOW POLICY

CANCELLATIONS SHOULD BE MADE PRIOR TO 8:00 AM THE DAY OF APPOINTMENTS TO AVOID PENALTLY. WHEN POSSIBLE, A 24 HOUR NOTICE IS APPRECIATED.

CANCELLATIONS LATER THAN 8:00 AM THE DAY OF AN APPOINTMENT WILL RESULT IN THE FOLLOWING:

* 1ST TIME: A REMINDER WILL BE GIVEN
* 2ND+ TIME: A $50 FEE WILL BE CHARGED TO YOUR ACCOUNT

NO SHOWS

* 1ST TIME: A $50 FEE WILL BE CHARGED TO YOUR ACCOUNT
* 2ND+ TIME: $120 FEE WILL BE CHARGED TO YOUR ACCOUNT

IF YOUR INJURY IS WORK RELATED, THE SAME POLICY APPLIES. AFTER THE THIRD CANCELLATION/NO SHOW, YOUR CASE MANAGER OR CLAIMS ADJUSTER WILL BE NOTIFIED OF YOUR LACK OF ATTENDANCE, AND THE WORKERS COMPENSATION INSURANCE WILL BE CHARGED THE FULL AMOUNT OF YOUR VISIT

I HAVE READ, UNDERSTAND, AND AGREE WITH STAY FIT PHYSICAL THERAPY & CORE WELLNESS, INC.'S FINANCIAL, ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE MEDICAL INFORMATION/CONSENT OF TREATMENT, AND CANCELLATION POLICIES.

SIGNATURE	DATE

NEW PATIENT REGISTRATION

PLEASE PRINT

NOTICE OF PRIVACY PRACTICES EFFECTIVE JANUARY 1, 2009	
OUR COMMITMENT AT STAY FIY PHYSICAL THERAPY & CORE WELLNESS, INC. IS TO SERVE OUR CUSTOMERS WITH PROFESSIONALISM AND CARE, BEING SURE AT ALL TIMES TO PROTECT THE PRIVEACY AND SECURITY OF ALL PROTECTED HEALTH INFORMATION. DURING THE COURSE OF SERVING YOU, IT MAY BE NECESSARY TO SHARE INFORMATION WITH OTHER HEALTH CARE PROVIDERS OR BUSINESS ASSOCIATES. THE FOLLOWING ARE EXAMPLES OF INSTANCES WHRE INFORMATION MAY SHARED: ☐ FOR PAYMENT PURPOSES, WE MAY EMPLOY A BILLING SERVICE. ☐ DURING TREATMENT, WE MAY FIND IT NECESSARY TO CONTACT YOUR PHYSICIANS. AT STAY FIT PHYSICAL THERAPY & CORE WELLNESS INC., WE ARE COMMITTED TO OBEYING ALL FEDERAL, STATE, AND LOCAL LAWS AND REGULATIONS REGARDING PRIVACY PRACTICES. IF ANY OTHER USSES OR DISCLOSERS OTHER THATN THE ONES LISTED ABOVE ARE NEEDED, INFORMATION WILL ONLY BE RELEASED WITH THE WRITTEN AUTHORIZATION OF THE INDIVIDUAL IN QUESTION. THIS WRITTEN AUTHORIZATION MAY BE REVOKED AT ANY TIME BY THE INDIVIDUAL, AS PROVIDED BY LAW. WE ARE VIGILANT IN PROTECTING PATIENT CONFIDENTIALITY. NO INFORMATION REGARDING YOU IS SHARED OR DISTRIBUTED WITH ANY ORGANIZATION WITHOUT YOUR SIGNED AUTHORIZATION. IF YOU HAVE ANY QUESTIONS OR COMMENTS REGARDING YOUR PROTECTED HEALTH INFORMATION, FEEL FREE TO CONTACT OUR BUSINESS MANAGER AT 847-255-2348.	
I HAVE READ, UNDERSTAND, AND AGREE WITH THE ABOVE NOTICE OF PRIVACY PRACTICES, AND AUTHORIZE THE RELEASE OF MY MEDICAL INFORMATION TO THE ABOBE MENTIONED PARTIES.	
SIGNATURE	DATE

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HEALTH QUESTIONNAIRE

HEIGHT: WEIGHT: LOWEST ADULT WEIGHT: HIGHEST ADULT WEIGHT:

EDUCATION: [ ] GRADE SCHOOL [ ] HIGH SCHOOL [ ] COLLEGE [ ] GRAD SCHOOL

DATE OF YOUR LAST PHYSICAL

PLEASE LIST 1-2 THINGS YOU WOULD LIKE TO CHANGE ABOUT YOUR DIET:

DESCRIBE YOUR TYPICAL EATING PATTERN:

WHAT DIETS/METHODS HAVE YOU TRIED TO LOOSE WEIGHT? WHAT WAS SUCCESSFUL? WHAT WERE YOUR BARRIERS?

PLEASE LIST CURRENT MEDICATION/ VITAMINS/HERBAL SUPPLEMENTS

ADDITIONAL INFORMATION (PLEASE LIST FOOD ALLERGIES/INTOLERANCES/PAST SURGERIES, ETC.

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS OR PROBLEMS?

PLEASE INDICATE "C" FOR CURRENT PROBLEMS OR "P" FOR PAST PROBLEMS

RESPIRATORY	____________________	____________________
GASTROINTESTINAL	____________________	____________________
CARDIOVASCULAR	____________________	____________________
MUSCOSKELETAL	____________________	____________________
ENDOCRINE	____________________	____________________
SKIN	____________________	____________________
OTHER	____________________	____________________

NEW PATIENT REGISTRATION

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JOB/WORKSTATION DESCRIPTION:

PHYSICAL ACTIVITY (TYPE/DURATION/#DAYS PER WEEK)

NEW PATIENT REGISTRATION

PLEASE PRINT

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