

Stay Fit Physical Therapy Core Wellness, Inc.

NEW PATIENT REGISTRATION						
THERAPIST			APPOINTMENT DATE:			
LAST NAME	FIRST NAME	MI	DOB	SOCIAL SECURITY	SEX	
MARITAL STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		Have you been treated at Stay Fit Physical Therapy clinic before? If yes, when?		EMAIL ADDRESS		
EMPLOYMENT STATUS Employed <input type="checkbox"/> Student: FT <input type="checkbox"/> PT <input type="checkbox"/>		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						
IS THIS AN INJURY RELATED CONDITION? IF SO, PLEASE INDICATE REASON: (PLEASE CIRCLE)						
JOB RELATED		CAR ACCIDENT		HOME ACCIDENT		OTHER: _____
PLEASE INDICATE THE DATE OF YOUR INJURY: / /			DATE OF YOUR FIRST SYMPTOM: / /			
NAME OF INSURANCE ADJUSTER			PHONE			
PLEASE DESCRIBE YOUR INJURY/ACCIDENT:						
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)			

Stay Fit Physical Therapy Core Wellness, Inc.

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.

DENIAL OF PAYMENT

* 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.

THIRD PARTY BILLING

* THIRD PARTY BILLING I UNDERSTAND THAT THIRD PARTY BILLING TO ATTORNEYS OR THIRD PARTY MOTOR VEHICLE CARRIERS IS AVAILABLE, BUT I AM ULTIMATELY RESPONSIBLE FOR UNPAID BILLS OVER 1 YEAR OLD.

FINANCIAL RESPONSIBILITY

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

INTEREST

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

RETURNED CHECKS

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

PAYMENT OPTIONS

* WE ACCEPT CASH, CHECKS, VISA, MASTERCARD AND DISCOVER. (NO AMERICAN EXPRESS)

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.

CANCELLATION / NO SHOW POLICY

A twenty four hour notice is required for all cancellations. In the event of an unforeseen emergency, please call prior to 8:00 am the day of the appointment to avoid penalty.

CANCELLATIONS Later than 8:00 am the day of the 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

Stay Fit Physical Therapy & Core Wellness, Inc.
ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have read and comprehend the Notice of Privacy Practices for Stay Fit Physical Therapy & Core Wellness, Inc. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to Stay Fit Physical Therapy & Core Wellness, Inc. to release any of my protected healthcare information.

Patient's or Authorized Representative's Printed Name & Date

Patient's or Authorized Representative's Signature

To view the full Notice of Privacy Practices document go to:
www.stayfitpt.com/SFPTPrivacy

WAIVER AND RELEASE

I acknowledge that my attendance at or use of Stay Fit Physical Therapy & Core Wellness, Inc. or participating in any activities or programs, including without limitation my use of the equipment and facilities, could cause injury to me. As a material consideration for Stay Fit Physical Therapy & Core Wellness, Inc. to permit me to become a member and to permit me and my guests to use the facilities, I, on my own behalf and on behalf of my guests, hereby assume all risks of personal injury, death, property loss or other damages which may results from or arise out of attendance at or use of the facilities or participation in any of Stay Fit's programs and activities. The foregoing risks shall include, but not limited to, risks associated with group exercises, fitness equipment, weight lifting, exercise, massage services, theft, changing rooms, use of the equipment, facilities, or health and fitness advisory services. I understand that the foregoing waive of liability on my behalf and on behalf of my guests shall apply to any of the claims against Stay Fit Physical Therapy & Core Wellness, Inc. and/or its owners, shareholders, officers, directors, employees, agents, or affiliates and their successors and assigns for such personal injury, property loss or other damages connected to or arising out of any of the aforesaid risks. I also understand that some of the classes suggest taking off shoes and declare that I am aware of the risks, and hereby agree to accept responsibility for any and all injury.

I, on behalf of myself and my heirs, executors, administrators and assigns, fully and forever release and discharge Stay Fit Physical Therapy & Core Wellness, Inc. and its affiliates, from and all claims, damages, rights of action or causes of action, present or future, known or unknown, anticipated or unanticipated, resulting from or arising out of my attendance at or use of the facilities or participating in any of the programs or activities of Stay Fit Physical Therapy & Core Wellness, Inc. including those that rise out of the negligence of Stay Fit and its affiliates. Further, I hereby release and discharge Stay Fit and its affiliates for any and all liabilities for any loss, or theft of, or damage to personal property, including without limitation automobiles and the content of lockers.

I represent to Stay Fit that I am physically fit to perform those activities which I may undertake at Stay Fit that I am solely responsible for the health risks associated with such activities. I understand that any evaluation or assessment of my physical fitness and any recommendation of activities made by Stay Fit shall not be substitute for obtaining such evaluation, assessment, or recommendation from my physician before undertaking a physical exercise program or engaging in any of the activities at Stay Fit.

I understand that Stay Fit recommends that I be examined by my physician and that I consult with my physician regularly during the time that I am engaging in activities at Stay Fit. I acknowledge that the advice of Stay Fit and its affiliates, including its employees may be limited in scope and is not a substitute for medical supervision and advice. I authorize Stay Fit to send me emails at my address I provided and I understand that I may terminate such authorization at any time with written notice to Stay Fit.

I understand that the massage I receive is provided for the purpose of relaxation and the relief of muscular tension only. I have no known medical condition that would contraindicate massage and understand that massage therapists are not qualified to diagnose, adjust, prescribe, or treat any physical or mental illness. This consent is intended as a waiver of liability for all massage therapists employed by Stay Fit Physical Therapy & Core Wellness, Inc., as well as Stay Fit Physical Therapy & Core Wellness, Inc.

I acknowledge that I carefully read this Waiver and Release and fully understand that it is a waiver and release of liability.

Signed by: _____ Date: _____
(Please Print)

Signature: _____ Witness: _____

Stay Fit Physical Therapy & Core Wellness, Inc.
Stay Fit Health Questionnaire

Personal Information

Name: _____ Right Handed: Left Handed:
Education: Elementary High School Trade School College Graduate School
Employment: Full Time Part Time
Describe your daily activity or job position: _____

Activities: Sports _____
Hobbies _____
Emergency Contact: _____ Relationship: _____
Home Phone: _____ Mobile Phone: _____

Physical History

Please list most current injuries/accidents: _____

Have you ever received physical therapy? _____ If yes, when & why? _____

Please list any recent surgeries? _____

Lifestyle

Do you smoke? Y/N
Do you drink alcohol? Y/N
How many hours of sleep do you average per night? ____
Describe your current exercise program? _____

Personal Evaluation

Check all that apply.

Unable to participate in normal hobbies/interests? <input type="checkbox"/>	Nervousness? <input type="checkbox"/>
Significant Stress: Work <input type="checkbox"/> Home <input type="checkbox"/> Other <input type="checkbox"/>	Forgetfulness? <input type="checkbox"/>
Difficult with self care? <input type="checkbox"/>	Grief due to family death? <input type="checkbox"/>
Excessive moodiness? <input type="checkbox"/>	Transportation problems? <input type="checkbox"/>
Depression? <input type="checkbox"/>	Other? <input type="checkbox"/>

Medical History

Please indicate "C" for Current problem or "P" for past problems:

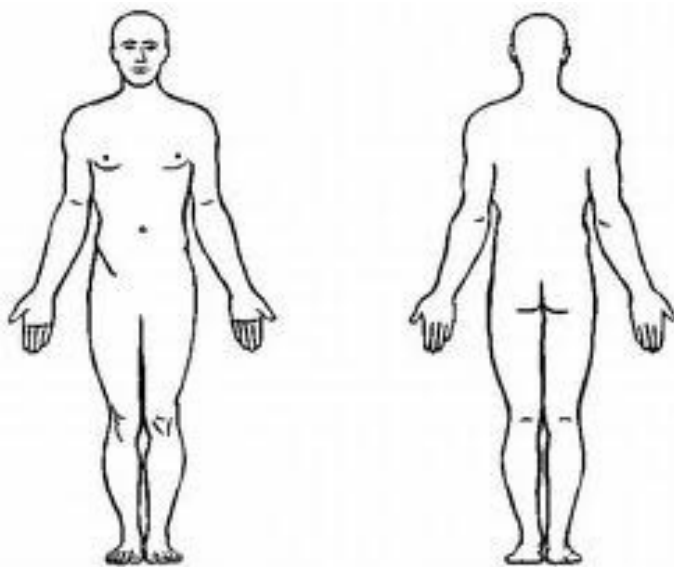
- | | | |
|--|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Recent Weight Loss/Gain |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Heart Condition/Pacemaker | <input type="checkbox"/> Recurring Back Pain |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hernias | <input type="checkbox"/> Recent Surgery |
| <input type="checkbox"/> Bone Fracture/Sprain | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Joint Injury | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Leg Pain | ___ On Exertion |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Loss of Appetite | ___ Lying Flat |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Skin Infection/Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Numbness/Tingling Sensation | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Easy Bruising | ___ Arm(s) ___ Hand(s) | <input type="checkbox"/> Sleeping Difficulties |
| <input type="checkbox"/> Epilepsy | ___ Leg(s) ___ Foot/Feet | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Frequent Headaches/Migraine | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Varicose Veins |

Medications

List all current medications and dosages: _____

Current Pain Level

Please indicate on this image what body area your are currently experiencing pain:



Please clearly describe your pain below:

Please mark on the scale what best describes your pain level:

- | | | | | | | | | | |
|---------|---|---|---------------|---|---|--------------|---|---|----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| No Pain | | | Moderate Pain | | | Extreme Pain | | | |