

STAY FIT

PHYSICAL THERAPY & CORE WELLNESS, INC

Medical Registration

Patient Information

Name: _____ Today's Date: _____

Date of Birth: _____ Gender: M F Email for Apt Reminders: _____

Address: _____

City: _____ State: _____ Zip: _____

Best Phone Number: _____ Alternate Phone: _____

How did you hear about us? _____

Is this your first time being treated by us? Yes No if yes, please describe previous treatments: _____

Emergency Contact: _____ Relationship: _____

Phone # _____ Alternate Phone: _____ [] cell [] work

Referring Physician Information

MD Name: _____ Address: _____

Phone: _____ Fax: _____

Reason for Visit

Is this an accident related condition? Yes No if yes, please indicate reason: (circle one)

Job Related Car Accident Home Accident Other: _____

Date of Injury _____ Date of first symptom: _____ Describe injury: _____

Payer Information

Primary Ins. Co. Name: _____ Insured's Name: _____

Relationship to patient: _____ Phone: _____ Ins. Date of Birth: _____

Policy ID #: _____ Group. # _____ Insurance Phone: _____

Secondary Ins. Co. Name: _____ Insured's Name: _____

Relationship to patient: _____ Phone: _____ Ins. Date of Birth: _____

Policy ID #: _____ Group. # _____ Insurance Phone: _____

Scan



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Medical Registration

Assignment of Insurance Benefits

_____ I authorize that the payment of my insurance benefits be made directly to Stay Fit
Initials Physical Therapy & Core Wellness, Inc. for any services that are reimbursable by my
insurance company or any third party payers.

Medicare and Workers Compensation Information

_____ I certify that the information I have provided to Stay Fit Physical Therapy & Core
Initials Wellness, Inc. for payment under the Social Security Act (Medicare) or under the Workers
Compensation Program is correct, including but not limited to any related accidents/
illness or other insurers/payers available.

Guarantee of Payment

I understand that all payments designated as "the patient's responsibility" are due and payable at the time of service. I guarantee that I will pay:

_____ My designated portion including co-pays /co-insurance and my deductible.
Initials

_____ A minimum of 50% is due at the time of services rendered when balance exceeds \$100.
Initials

_____ All amounts due for services billed by Stay Fit Physical Therapy & Core Wellness, Inc
Initials

_____ All amounts due for services billed by Stay Fit Physical Therapy & Core Wellness, Inc.,
Initials but paid directly to me.

_____ All amounts due for services billed by Stay Fit Physical Therapy & Core Wellness, Inc. to
Initials a Workers' Compensation payer which was subsequently declared by my employer to be
A non-eligible claim.

_____ All amounts due for claims submitted by Stay Fit Physical Therapy & Core Wellness, Inc.,
Initials to my insurance company and not paid by 90 days

_____ Interest at the rate of 1.5% on billed balances over 30 days unless monthly
Initials payments are being made.

Cancellation/No Show Policy

_____ Cancellations less than 24 hours prior to an appointment scheduled time will result in a
Initials \$50 fee. No shows will result in a fee of \$120. Fees are charged to my account.

_____/_____
Patient or Authorized Representative Signature Date

Scan





Waiver & 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 result 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 waiver 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 any 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: _____ Signature: _____ Date: _____
(Please Print)

Parent or Guardian of Minor Child _____ Witness: _____



PHYSICAL THERAPY & CORE WELLNESS, INC

Health Questionnaire

Personal Information

Name: _____ Phone: (____) ____ - _____

Describe your daily activity or job position: _____

Right Handed or Left Handed

What sports do you play?

Hobbies?

Physical History

Please list most current injuries/accidents: _____

Please list any recent surgeries? _____

Have you ever received physical therapy? Yes | No If yes, When? _____

Why were you treated for Physical Therapy: _____

Lifestyle

Do you smoke? Y | N How many hours of sleep do you average per night? _____

How frequently do you consume alcohol? Never 1-3 times per week 3-5 6 or more

Describe your current exercise program? _____

Please check all that apply:

Unable to participate in normal activities

Significant stress at:

Work Home Other

Difficult with self care

Excessive moodiness

Depression

Nervousness

Forgetfulness

Grief due to family death

Transportation problems

Other: _____

Medications

List all current medications and dosages: _____

Health Questionnaire

Please check Current and/or past problems:

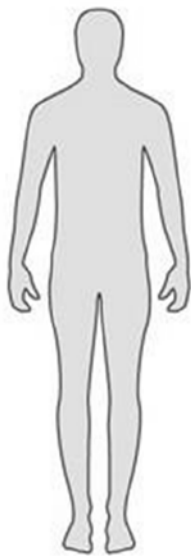
	Past	Present		Past	Present
Allergies			Leg Pain		
Artificial Joint			Loss of Appetite		
Arthritis			Muscle Weakness		
Bone Fracture/Sprain			Tingling Sensation?		
Blood Clots			Night sweats		
Cancer			Osteoporosis		
Chest Pain			Pregnancy		
Dizziness			Recent weight		
Diabetes			Loss/Gain		
Easy Bruising			Recurring back pain		
Epilepsy			Recent surgery		
Fainting Spells			Seizures		
Fibromyalgia			Shortness of breath		
Frequent Headaches			Skin infection		
Glaucoma			Sleep apnea		
Heart Condition			Sleeping difficulties		
Pacemaker?			Stroke		
Hernias			Thyroid		
High Blood Pressure			TMJ		
Joint Injury			Varicose Veins		

Current Pain Level(s)

Please indicate on this image what body area(s) are currently experiencing pain:



FRONT



BACK

Location: _____ (Use Diagram to indicate pain Location)

When did your Pain first Begin? _____

Related to (check one) :

- accident at work accident at home
 following surgery following illness
 auto accident slow onset / know known injury

Description: dull tender tiring sharp stabbing
shooting throbbing burning aching cramping

Current pain level:
(least) 0 1 2 3 4 5 6 7 8 9 10 (worst)

At best / at rest / most comfortable position:
(least) 0 1 2 3 4 5 6 7 8 9 10 (worst)

At night: Wakes at night: yes No

Frequency: _____
(Least) 0 1 2 3 4 5 6 7 8 9 10 (worst)



Notice of Privacy Practices Acknowledgement Receipt

My signature below indicates that I have been given 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