PT by the Sea, Inc.

REGISTRATION FORM

1721 Allens Lane Ste 101
Wilmington NC 28403
(910) 256 - 4442

PATIENT INFORMATION

PATIENT'S LAST NAME:	FIRST NAME:	MIDDLE:	☐ MR. ☐ MISS. ☐ MRS. ☐ MS.	MARTIAL STATUS (check one) ☐ Single ☐ Married ☐ Divorced ☐ Widowed

IS THIS YOUR LEGAL NAME? ☐ YES ☐ NO	IF NO, WHAT IS YOUR LEGAL NAME ?	(FORMER NAME):	BIRTHDATE: / /	AGE :	SEX : ☐ F ☐ M

STREET ADDRESS / P.O. BOX:	CITY :	STATE :	ZIP :

EMAIL ADDRESS :	SOCIAL SECURITY NUMBER:	PHONE 1 ( ) ☐ Cell ☐ Home ☐ Work
		PHONE 2 ( ) ☐ Cell ☐ Home ☐ Work

WORK INFORMATION

OCCUPATION	EMPLOYER :	EMPLOYER PHONE NO : ( )

REFERRAL INFORMATION - Patient was referred to PT By the Sea by:

☐ DOCTOR : _____ ☐ INSURANCE PLAN ☐ HOSPITAL ☐ FAMILY MEMBER ☐ FRIEND ☐ OTHER : _____

OTHER FAMILY MEMBERS (PAST OR PRESENT) SEEN AT ***PT BY THE SEA*** :

IN CASE OF EMERGENCY

NAME OF LOCAL FRIEND OR RELATIVE (NOT LIVING AT SAME ADDRESS):	RELATIONSHIP TO PATIENT:	PHONE 1 ( ) ☐ Cell ☐ Home ☐ Work
		PHONE 2 ( ) ☐ Cell ☐ Home ☐ Work

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE,

I AUTHORIZE MY INSURANCE BENFITS TO BE PAID DIRECTLY TO ***PT BY THE SEA, INC*** .

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE.

I AUTHORIZE ***PT BY THE SEA, INC.*** OR INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIM.

X _____ _____

PATIENT / GUARDIAN SIGNATURE DATE

PT by the Sea, Inc.

INTAKE FORM

1721 Allens Lane Ste 101
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PATIENT'S NAME:

TODAY'S DATE:

WHAT IS YOUR DIAGNOSIS/THE REASON YOU'RE SEEKING CARE?

When did your syptoms begin?

Month Day Year

What caused the symptoms?

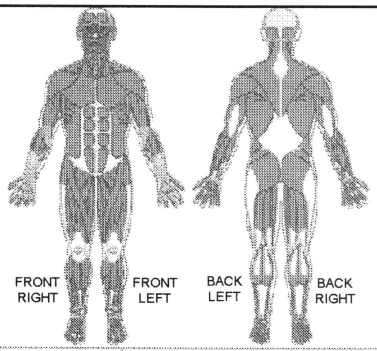
IS YOUR PAIN :

☐ CONSTANT (OCCURING ALL THE TIME)

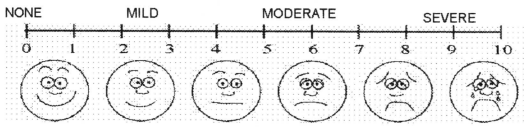
☐ INTERMITTENT (COMES AND GOES)

WHERE IS YOUR PAIN LOCATED ?

(Use the diagram to indicate location of your pain)



RATE YOUR LEVEL OF PAIN



PAIN LEVEL NOW: # _____

PAIN LEVEL AT BEST: # _____

PAIN LEVEL AT WORST: # _____

Describe what type of pain you feel

- ☐ Aching
- ☐ Burning
- ☐ Constant
- ☐ Cramping
- ☐ Deep
- ☐ Dull
- ☐ Weak
- ☐ Heavy
- ☐ Numb
- ☐ Pins and Needles
- ☐ Stabbing
- ☐ Throbbing
- ☐ Variable

What makes your pain worse?

- ☐ Reaching back
- ☐ Lying flat
- ☐ Getting up out of bed
- ☐ Dressing/grooming
- ☐ Cooking
- ☐ Carrying items
- ☐ Climbing stairs
- ☐ Twisting
- ☐ Lifting
- ☐ Lifting heavy weights
- ☐ Pulling
- ☐ Raising arm over head
- ☐ Looking up/down
- ☐ Walking

What relieves your pain

- ☐ Ice
- ☐ Heat
- ☐ Nothing
- ☐ Stretching
- ☐ Exercise
- ☐ Pain Medication
- ☐ Lying flat
- ☐ Avoiding activity

How often do you exercise

- ☐ None
- ☐ Usually once per week
- ☐ Usually twice per week
- ☐ Usually 3 times per week
- ☐ 4 or more times per week

Does your daily routine, or work, aggravate your injury?

- ☐ No
- ☐ I am unable to participate in my normal routines or work
- ☐ My routine/work usually impacts my injury 1 day per week
- ☐ My routine/work usually impacts my injury 2 days per week
- ☐ My routine/work usually impacts my injury 3 or more days per week
- ☐ My routine/work aggravates my injury every day, but I try to cope

How many times have you fallen in the past year?

- ☐ None
- ☐ Once
- ☐ Twice
- ☐ 3 times
- ☐ 4 times
- ☐ 5 times
- ☐ 6 or more times

Were you injured?

- ☐ Yes
- ☐ No

Height: _____

Weight: _____

Does your diagnosis impact your ability to do your job?

- ☐ I am retired
- ☐ The diagnosis prevents me from working
- ☐ I can only work part time
- ☐ I can work, but with great difficulty
- ☐ I can work, but with minor difficulty
- ☐ The diagnosis does not impact my ability to work

Does your diagnosis impact your ability to attend school?

- ☐ The diagnosis prevents me from attnding school
- ☐ I am in school, but the diagnosis has a big impact
- ☐ I am in school and the diagnosis has a minor impact
- ☐ School is normal, but I can't practice in sports
- ☐ School is normal, no impact
- ☐ Not applicable

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Medical History Form

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DO YOU HAVE ANY ALLERGIES TO MEDICATION, FOOD, LATEX OR TAPE ? ☐ YES ☐ NO

IF **YES**, PLEASE LIST: _____

DO YOU TAKE ANY MEDICATIONS ? ☐ YES ☐ NO IF **YES**, PLEASE LIST **NAME, DOSAGE, FREQUENCT AND ROUTE OF ADMINISTRATION** BELOW:

_____

_____

_____

DO YOU HAVE A HISTORY OF THE FOLLOWING :			DATE / COMMENT
ANEMIA	☐ YES	☐ NO	
BACK PAIN	☐ YES	☐ NO	
BRONCHITIS	☐ YES	☐ NO	
DRINK ALCOHOL	☐ YES	☐ NO	
GOUT	☐ YES	☐ NO	
HERNIA	☐ YES	☐ NO	
PARKINSONS	☐ YES	☐ NO	
FREQUENT / SEVERE HEADACHES	☐ YES	☐ NO	
STROKE/TA	☐ YES	☐ NO	
VISION DIFFICULTIES	☐ YES	☐ NO	
WOMENS HEALTH ISSUES	☐ YES	☐ NO	
PACEMAKER	☐ YES	☐ NO	
ANGINA	☐ YES	☐ NO	
BLOOD CLOT/EMBOLI	☐ YES	☐ NO	
HEART DISEASE	☐ YES	☐ NO	
EMPHYSEMA	☐ YES	☐ NO	
HEARING DIFFICULTIES	☐ YES	☐ NO	
HIGH BLOOD PRESSURE	☐ YES	☐ NO	
PNEUMONIA	☐ YES	☐ NO	

DO YOU HAVE A HISTORY OF THE FOLLOWING :			DATE / COMMENT
SLEEPING PROBLEMS	☐ YES	☐ NO	
THYROID PROBLEM	☐ YES	☐ NO	
WEAKNESS	☐ YES	☐ NO	
ASTHMA	☐ YES	☐ NO	
BOWEL/BLADDER PROBLEMS	☐ YES	☐ NO	
DIZZINESS	☐ YES	☐ NO	
EPILEPSY/SEIZURES	☐ YES	☐ NO	
HEART ATTACK	☐ YES	☐ NO	
KIDNEY DISEASE ?	☐ YES	☐ NO	
PREGNANT	☐ YES	☐ NO	
SMOKE CIGARETTES	☐ YES	☐ NO	
VARICOSE VEINS	☐ YES	☐ NO	
WEIGHT LOSS/ENERGY LOSS	☐ YES	☐ NO	
JOINT REPLACEMENT	☐ YES	☐ NO	
PINS OR METAL IMPLANT	☐ YES	☐ NO	
ARTHRITIS	☐ YES	☐ NO	
NUMBNESS/TINGLING	☐ YES	☐ NO	
CRP SYNDROME	☐ YES	☐ NO	
DIABETES (TYPE)	☐ YES	☐ NO	
(If yes, please list shoe size)			

ARE YOU RECEIVING OR ARE YOU ELIGIBLE TO RECEIVE **HOME HEALTH CARE SERVICES?** ☐Yes ☐No

*Medicare **WILL NOT** cover physical therapy if you are receving **ANY** type of home health services, and you will be responsible for the bill.

Was the inury a result of an auto accident ☐Yes ☐No

Does the injury involve workers Compensation ☐No ☐Yes If yes, name of employer:

X _____ _____

PATIENT / GUARDIAN SIGNATURE DATE

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Medical History Form

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DO YOU HAVE A HISTORY OF THE FOLLOWING :			DATE / COMMENT
I HAVE RECEIVED PT AT HOME	☐ YES	☐ NO	
I USE A CANE	☐ YES	☐ NO	
I USE A WHEEL CHAIR	☐ YES	☐ NO	
I USE A WALKER	☐ YES	☐ NO	
I AM A CAREGIVER	☐ YES	☐ NO	
I LIVE ALONE	☐ YES	☐ NO	
MY HOME HAS STAIRS	☐ YES	☐ NO	

DO YOU HAVE A HISTORY OF THE FOLLOWING :			DATE / COMMENT
INFECTIOUS DISEASE	☐ YES	☐ NO	
PELVIC FLOOR ISSUES	☐ YES	☐ NO	
CANCER	☐ YES	☐ NO	
INCONTINENCE	☐ YES	☐ NO	
OTHER SURGERY	☐ YES	☐ NO	
VERTIGO/BALANCE	☐ YES	☐ NO	

PLEASE COMMENT ON ITEMS YOU HAVE CHECK YES ABOVE: (Be specific, include dates / names of procedures / left or right side)

Do you: ☐ Smoke tobacco ☐ Chew tobacco ☐ Snuff tobacco ☐ All of the above ☐ None

Have you ever received advice or counseling to help you stop using tobacco? ☐ Yes ☐ No

DO YOU HAVE ANY SPECIFIC LIMITATIONS WE SHOULD KNOW ABOUT DUE TO PAST MEDICAL HISTORY OR DOCTORS RECOMMENDATIONS ? ☐ YES ☐ NO

IF **YES**, PLEASE LIST:

CANCELLATION / NO SHOW POLICY

PT By The SEA is a small business whose goal is to provide one on one patient care. We strive to provide the best individualized and skilled care that we are capable of giving. In order to do so, we feel that it is most important to give one on one attention to each client for every (40) forty minute sessions. Therefore, we do not double book the schedule. If a client does not show up or cancels on short notice, we can not provide the care to you or to other clients who may be on our waiting list.

In order for **PT By The SEA** to continue providing these services, we request your consideration to us and other clients in giving us ample notice prior to missing an appointment. **If you call us on the day of your appointment a $40 fee will be issued**. If your appointment can be rescheduled for that same day, the fee will be waived. The fee will also be waived in case of severe inclement weather or emergency. **Not showing up for your appointment without notice will result in a $50 charge to your account.**

***Call (910)256-4442 prior to 5:00pm the business day before your scheduled appointment to avoid the $40 cancellation fee.**

By signing below you acknowledge that you have read the above policy and understand that if you cancel on the same day of service or no show for a scheduled appontment, you will be charged $40 or $50, respectively, for which you are financially responsible. This amount will be due prior to receiving any additional treatments.

I AGREE THAT THE ABOVE STATED INFORMATION IS CURRENT AND ACCURATE TO THE BEST OF MY KNOWLEDGE, AND AGREE TO THE CANCELLATION TERMS LISTED ABOVE.

X _____ _____

PATIENT SIGNATURE or PARENT / GUARDIAN (on behalf of minor patient) DATE

PT by the Sea, Inc.

Consent, Release and Authorization Form

1721 Allens Lane Ste 101
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CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for ***PT By The SEA, Inc.*** to furnish medical care and treatment to _____ considered necessary and proper in diagnosing or treating his/her physical and mental condition.
PATIENT'S NAME

RELEASE OF INFORMATION

I understand that **PT by the Sea, Inc.** may use or disclose my personal health information for the purposes of carrying out a 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, if I notify the practice.

I authorize release of medical information necessary for payment of any claim to **PT by the Sea, Inc.**

RESPONSIBILITY AGREEMENT

Our Physical Therapists welcome you to our practice and are committed to providing you with the best possible care. It is our pleasure to serve you and your health care needs.

Please be advised that payment is due at the time of service. If you have health insurance, we expect your co-pay and any deductible at the time of service. We will file your insurance as a courtesy to you. Please be aware your insurance is a contract between you and your insurance company. We will make every reasonable attempt to collect payment for PT services, however, the bill is ultimately your responsibility.

DESIGNATED INDIVIDUALS AUTHORIZATION

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

AUTHORIZED DESIGNEE'S NAME : _____ RELATIONSHIP TO PATIENT : _____

AUTHORIZED DESIGNEE'S NAME : _____ RELATIONSHIP TO PATIENT : _____

SIGNATURE

By signing below, I acknowledge that I have read the above consent, release of information, responsibility agreement and designated individual authorization statements. I also hereby agree the above information is true to the best of my knowledge, and I have had the opportunity to express any concerns or questions regarding any policies set in place by **PT by the Sea, Inc.**

Printed name: _____ Date: _____

Signature: X _____