



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:	<input type="checkbox"/> MR. <input type="checkbox"/> MISS. <input type="checkbox"/> MRS. <input type="checkbox"/> MS.	MARTIAL STATUS (check one) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
<input type="checkbox"/> YES <input type="checkbox"/> NO IS THIS YOUR LEGAL NAME?	IF NO, WHAT IS YOUR LEGAL NAME ?		(FORMER NAME):	BIRTHDATE: / /	AGE :	<input type="checkbox"/> F <input type="checkbox"/> M SEX :
STREET ADDRESS / P.O. BOX:			CITY :	STATE :	ZIP :	
EMAIL ADDRESS :			SOCIAL SECURITY NUMBER:	PHONE 1 ()	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	
				PHONE 2 ()	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	

WORK INFORMATION		
OCCUPATION	EMPLOYER :	EMPLOYER PHONE NO : ()

REFERRAL INFORMATION - Patient was referred to PT By the Sea by:	
<input type="checkbox"/> DOCTOR : _____	<input type="checkbox"/> INSURANCE PLAN <input type="checkbox"/> HOSPITAL <input type="checkbox"/> FAMILY MEMBER <input type="checkbox"/> FRIEND <input type="checkbox"/> OTHER : _____
OTHER FAMILY MEMBERS (PAST OR PRESENT) SEEN AT <i>PT BY THE SEA</i> :	

IN CASE OF EMERGENCY		
NAME OF LOCAL FRIEND OR RELATIVE (NOT LIVING AT SAME ADDRESS):	RELATIONSHIP TO PATIENT:	PHONE 1 () <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
		PHONE 2 () <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE,
 I AUTHORIZE MY INSURANCE BENEFITS 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

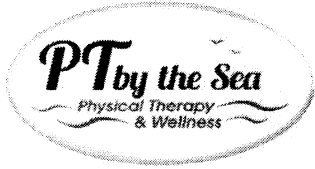


PT by the Sea, Inc.

INTAKE FORM

1721 Allens Lane Ste 101
 Wilmington NC 28403
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PATIENT'S NAME:		TODAY'S DATE:	
WHAT IS YOUR DIAGNOSIS/THE REASON YOU'RE SEEKING CARE?		When did your symptoms begin? Month _____ Day _____ Year _____	
What caused the symptoms?		IS YOUR PAIN : <input type="checkbox"/> CONSTANT (OCCURRING ALL THE TIME) <input type="checkbox"/> INTERMITTENT (COMES AND GOES)	
WHERE IS YOUR PAIN LOCATED ? (Use the diagram to indicate location of your pain)		RATE YOUR LEVEL OF PAIN	
		<p>NONE MILD MODERATE SEVERE</p> <p>0 1 2 3 4 5 6 7 8 9 10</p> <p>PAIN LEVEL NOW: # _____</p> <p>PAIN LEVEL AT BEST: # _____</p> <p>PAIN LEVEL AT WORST: # _____</p>	
Describe what type of pain you feel <input type="checkbox"/> Aching <input type="checkbox"/> Heavy <input type="checkbox"/> Burning <input type="checkbox"/> Numb <input type="checkbox"/> Constant <input type="checkbox"/> Pins and Needles <input type="checkbox"/> Cramping <input type="checkbox"/> Stabbing <input type="checkbox"/> Deep <input type="checkbox"/> Throbbing <input type="checkbox"/> Dull <input type="checkbox"/> Variable <input type="checkbox"/> Weak		What makes your pain worse? <input type="checkbox"/> Reaching back <input type="checkbox"/> Twisting <input type="checkbox"/> Lying flat <input type="checkbox"/> Lifting <input type="checkbox"/> Getting up out of bed <input type="checkbox"/> Lifting heavy weights <input type="checkbox"/> Dressing/grooming <input type="checkbox"/> Pulling <input type="checkbox"/> Cooking <input type="checkbox"/> Raising arm over head <input type="checkbox"/> Carrying items <input type="checkbox"/> Looking up/down <input type="checkbox"/> Climbing stairs <input type="checkbox"/> Walking	
How often do you exercise <input type="checkbox"/> None <input type="checkbox"/> Usually once per week <input type="checkbox"/> Usually twice per week <input type="checkbox"/> Usually 3 times per week <input type="checkbox"/> 4 or more times per week Does your daily routine, or work, aggravate your injury? <input type="checkbox"/> No <input type="checkbox"/> I am unable to participate in my normal routines or work <input type="checkbox"/> My routine/work usually impacts my injury 1 day per week <input type="checkbox"/> My routine/work usually impacts my injury 2 days per week <input type="checkbox"/> My routine/work usually impacts my injury 3 or more days per week <input type="checkbox"/> My routine/work aggravates my injury every day, but I try to cope		What relieves your pain <input type="checkbox"/> Ice <input type="checkbox"/> Nothing <input type="checkbox"/> Heat <input type="checkbox"/> Stretching <input type="checkbox"/> Exercise <input type="checkbox"/> Pain Medication <input type="checkbox"/> Lying flat <input type="checkbox"/> Avoiding activity	
How many times have you fallen in the past year? <input type="checkbox"/> None <input type="checkbox"/> Once <input type="checkbox"/> Twice <input type="checkbox"/> 3 times <input type="checkbox"/> 4 times <input type="checkbox"/> 5 or more times Were you injured? <input type="checkbox"/> Yes <input type="checkbox"/> No Height: _____ Weight: _____		Does your diagnosis impact your ability to do your job? <input type="checkbox"/> I am retired <input type="checkbox"/> The diagnosis prevents me from working <input type="checkbox"/> I can only work part time <input type="checkbox"/> I can work, but with great difficulty <input type="checkbox"/> The diagnosis does not impact my ability to work <input type="checkbox"/> Not applicable	
Does your diagnosis impact your ability to attend school? <input type="checkbox"/> The diagnosis prevents me from attending school <input type="checkbox"/> I am in school, but the diagnosis has a big impact <input type="checkbox"/> I am in school and the diagnosis has a minor impact <input type="checkbox"/> School is normal, but I can't practice in sports <input type="checkbox"/> School is normal, no impact <input type="checkbox"/> Not applicable			



PT by the Sea, Inc.

Medical History Form

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DO YOU HAVE ANY ALLERGIES TO MEDICATION, FOOD, LATEX OR TAPE ?

YES NO

IF YES, PLEASE LIST: _____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS ?

YES NO

IF YES, PLEASE LIST: _____

DO YOU HAVE A HISTORY OF THE FOLLOWING :

DATE / COMMENT

ANEMIA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
BACK PAIN	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
BRONCHITIS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
DRINK ALCOHOL	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
GOUT	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
HERNIA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
PARKINSONS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
HEADACHES ?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
STROKE/TA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
VISION DIFFICULTIES	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
WOMENS HEALTH ISSUES	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
PACEMAKER	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
ANGINA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
BLOOD CLOT/EMBOLI	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
HEART DISEASE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
EMPHYSEMA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
HEARING DIFFICULTIES	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
HIGH BLOOD PRESSURE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
PNEUMONIA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____

DO YOU HAVE A HISTORY OF THE FOLLOWING :

DATE / COMMENT

SLEEPING PROBLEMS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
THYROID PROBLEM	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
WEAKNESS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
ASTHMA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
BOWEL/BLADDER PROBLEMS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
DIZZINESS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
EPILEPSY/SEIZURES	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
HEART ATTACK	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
KIDNEY DISEASE ?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
PREGNANT	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
SMOKE CIGARETTES	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
VARICOSE VEINS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
WEIGHT LOSS/ENERGY LOSS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
JOINT REPLACEMENT	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
PINS OR METAL IMPLANT	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
ARTHRITIS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
NUMBNESS/TINGLING	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
CRP SYNDROME	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
DIABETES (TYPE)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____

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

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

Was the injury 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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DO YOU HAVE A HISTORY OF THE FOLLOWING :		DATE / COMMENT			
I HAVE RECEIVED PT AT HOME	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	INFECTIOUS DISEASE	<input type="checkbox"/>	_____
I USE A CANE	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	PELVIC FLOOR ISSUES	<input type="checkbox"/>	_____
I USE A WHEEL CHAIR	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	CANCER	<input type="checkbox"/>	_____
I USE A WALKER	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	INCONTINENCE	<input type="checkbox"/>	_____
I AM A CAREGIVER	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	OTHER SURGERY	<input type="checkbox"/>	_____
I LIVE ALONE	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	VERTIGO/BALANCE	<input type="checkbox"/>	_____
MY HOME HAS STAIRS	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____			

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

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 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 (45) forty-five minute sessions. Therefore, we do not double book the schedule. If a client does not show up or cancels in 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 consideration by your clients 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 **\$30 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 such as an impending hurricane or snowstorm.

***Call (910)256-4442 prior to 5:00pm the business day before your scheduled appointment to avoid the \$30 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 appointment, you will be charged \$30, 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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(910) 256 - 4442

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 _____