NEW PATIENT REGISTRATION FORM

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____

Male ☐ Female ☐ Married ☐ Single ☐ Cell Phone: _____

Employer: _____ Work Phone: _____

Email Address (please print): _____

MINOR PATIENTS

Parent Name: _____ Address: _____

Home Phone: _____ Work Phone: _____

**Please help us verify your insurance information.

Is your injury/issue related to any of the following: Injury/Illness_____ Work Accident_____ Auto Accident_____

Primary Ins. Co.:_____ Secondary Ins. Co.:_____

Address:_____ Address:_____

City:_____ State:_____ Zip:_____ City:_____ State:_____ Zip:_____

Insured:_____ DOB:_____ Insured:_____ DOB:_____

Relationship to Insured:_____ Relationship to Insured:_____

ID#:_____ Group#:_____ ID#:_____ Group#:_____

Workers' Compensation Ins. Co.:_____ Injury Date:_____

Address:_____ City:_____ State:_____ Zip:_____

Employer's Name:_____ Contact Person:_____

Claim #:_____ Phone #:_____

Auto Accident Ins. Co._____ Injury Date:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Policy # _____ Policyholder:_____

DEDUCTIBLE: Most insurance policies have a deductible in varying amounts, requiring you to meet your deductible (as stated on your insurance policy) before any insurance benefits will be covered. In the event that you have not met your deductible at the time you start you treatment, we would ask that you make payments towards your deductible at each visit until it is met.

CO-INSURANCE: Your insurance carrier will generally cover a percentage of the total charges for services rendered. The remaining percentage they do not cover is your responsibility and must be paid to University Physical Therapy.

PATIENT HISTORY

Name: _____ DOB: _____ Age: _____

Gender: M / F Height: _____ Weight: _____ Occupation: _____

Primary Care Physician: _____ Referring Physician: _____

Diagnosis: _____

How were you injured? (Please provide specific details):

_____

Date of Injury: _____ Surgery for this injury? _____ Surgery Date: _____

Please list your most significant symptoms and/or problems:

1._____ **2.**_____

3._____ **4.**_____

Previous Level of Function (check all that apply):

Independent with: ☐ Daily Activities ☐ Self Care ☐ Work / Vocation ☐ Care Giving ☐ Ambulation/Mobility ☐ Community Access

Functional Limits (check all that apply): ☐ Sleep ☐ Self Care ☐ Daily Activities ☐ Reaching / Pushing / Pulling ☐ Lifting / Carrying ☐ Sitting / Standing ☐ Mobility / Ambulation ☐ Community Access

Aggravating Factors (check all that apply): ☐ Sitting ☐ Standing ☐ Walking ☐ Stairs (up/down) ☐ Bending ☐ Voiding ☐ Lying Down ☐ Coughing / Sneezing

Current Work Status: ☐ Full Time ☐ Part Time ☐ Student ☐ Unemployed ☐ Disabled ☐ Light duty due to injury ☐ Not working due to injury Out of work since: _____

Current Level of Function / Able to perform:

Home Activities:	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Work Activities:	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Recreation Activities:	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

Recreational Activities / Hobbies (Please list): _____

_____

What date (approximately) did your present pain start? _____

PAIN: *(0 = None 5 = Moderate 10 = Extreme)*

At Worst:	0	1	2	3	4	5	6	7	8	9	10
Current:	0	1	2	3	4	5	6	7	8	9	10
At Best:	0	1	2	3	4	5	6	7	8	9	10

Do you smoke? ☐ Yes ☐ No # of packs/day _____

Are you pregnant? ☐ Yes ☐ No Due Date: _____

Latex Allergies? ☐ Yes ☐ No

My symptoms are currently: ☐ Getting Better ☐ About the Same ☐ Getting Worse

Is your pain affecting your sleep? ☐ Yes ☐ No

What treatments have you received for this issue so far? _____

Have you had an X-Ray, MRI or other test for this issue? _____

What makes your symptoms better? _____

What makes your symptoms worse? _____

Is there anything else we should know about your symptoms or medical history? _____

Have you had a history of falls / balance issues?

☐ 2 or more falls in the past year

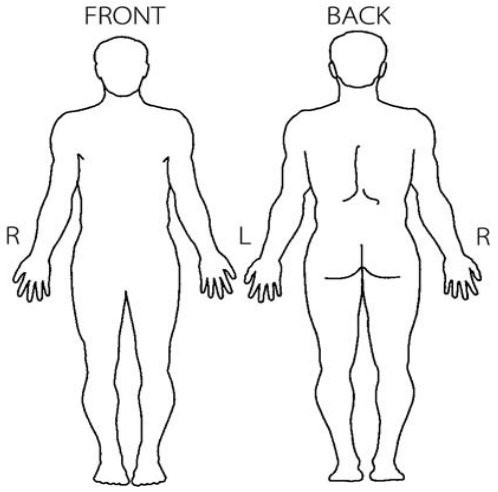
☐ Any fall in the past year that has resulted in injury

☐ No falls, or only one but without injury

Are you using an assistive device?

☐ Crutches ☐ Brace ☐ Walker ☐ Wheelchair ☐ Cane ☐ Splint ☐ Other_____

/////// Sharp	XXXXXXX Burning	0000000 Pins & Needles	====== Numb
ZZZZZ Dull			



Pain Frequency: ☐ Less than daily ☐ Daily ☐ Increases throughout day ☐ Constant ☐ Night
☐ Other: _____

Past Medical History: ***Check any conditions that you currently have or have had in the past.***

- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Osteoporosis
- ☐ Allergies/Asthma
- ☐ Diabetes
- ☐ Heart Problems
- ☐ Arthritis
- ☐ Seizures/Epilepsy
- ☐ Fever, Chills, Sweating
- ☐ Unexplained Weight Loss
- ☐ Infectious Disease
- ☐ Thyroid Problems
- ☐ Skin Disease
- ☐ Ulcers/Stomach Issues
- ☐ Stroke
- ☐ Depression
- ☐ Fibromyalgia
- ☐ Other_____
- ☐ Kidney Problems
- ☐ Change in Bowel/Bladder Function
- ☐ Broken Bones/Fracture
- ☐ Liver Disease
- ☐ Head Injury
- ☐ Dizziness
- ☐ Shortness of Breath
- ☐ Pace Maker

Past Surgical History: _____
_____

Current Medications:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Home Layout:
☐ 1 – Story ☐ 2 – Story ☐ Condo / Apartment ☐ Stairs / Steps ☐ Shower Stall ☐ Combo Bathtub Shower ☐ W/C Accessible

Durable Medical Equipment:
☐ None ☐ Tub Bench ☐ Shower Chair ☐ Bedside Commode ☐ Raised Toilet Seat ☐ Standard Walker ☐ Rolling Walker
☐ Hemi Walker ☐ Quad Cane ☐ Straight Cane ☐ Wheelchair

Identify 3 goals that you personally would like to achieve as a result of your therapy:

1. _____
2. _____
3. _____

* Are you currently under the care of a Home Health Agency? ☐ Yes ☐ No
* Have you had any other physical, occupational or speech therapy in this calendar year? ☐ Yes ☐ No

Signature: _____ Date: _____

The University of Rhode Island

University Physical Therapy

Independence Square, Kingston, RI 02881

Phone: (401) 874-2006 Fax: (401) 874-7099

Patient Consent

We ask that you take a few minutes to review the following information. In this way, we hope to give you a better understanding of the role of Physical Therapy and the Physical Therapist in your rehabilitation.

Who are Physical Therapists?

Physical Therapists (PTs) are licensed health care professionals who can help patients reduce pain and improve or restore mobility and function. PTs can teach patients how to prevent or manage their condition so that they will achieve long-term health benefits. PTs examine each individual and develop an individualized plan, using treatment techniques to promote mobility, improve strength, reduce pain, restore function, and prevent disability. In addition, PTs work with individuals to prevent the loss of mobility before it occurs by developing fitness- and wellness-oriented programs for healthier and more active lifestyles. PTs use a variety of hands-on techniques with or without various instruments, therapeutic exercise, and/or machines to re-establish proper posture, control pain, and restore mobility and function.

What Can I Expect During My Course of Treatment?

A Physical Therapist uses a thorough evaluation process to identify potential and existing problems with movement and function. With your input, they will formulate goals and plan a course of treatment to achieve those goals. Treatment typically consists of active components such as therapeutic exercise for balance, control, strength, or flexibility, and passive components where the therapist may use a variety of hands-on techniques, and/or instruments and machines to meet your treatment goals.

Are There Risks?

There are risks for any type of treatment. However, the risk of serious injury from a treatment provided by a Physical Therapist is very low. Because of the unfamiliar nature of some exercises, movements, or therapeutic procedures, you may experience some post-treatment muscle or joint soreness or aching. These sensations should decrease rapidly and disappear within a day or two. Joint manipulation and trigger point dry needling (TDN) can result in a short-term increase in pain and some soreness for a day or so after the treatment. In addition, TDN can result in bruising, a few drops of blood, infection, muscle or nerve irritation or a feeling of faintness or sweating during the treatment. More serious risks can occur, however, these are extremely rare. For joint manipulation there is a very small risk of joint dislocation or bone fracture. For TDN, these include puncture of the lung or bowel, and damage to the brainstem or spinal cord. Due to the nature of the needle used for TDN, the likelihood of significant tissue trauma is highly unlikely.

Direct Access Consent to Treatment

Direct Access is a term used in Physical Therapy to denote the evaluation and treatment of an individual without a referral from a physician or other healthcare provider. Direct Access to Physical Therapy is permitted in the state of Rhode Island under the *Rules and Regulations for Licensing Physical Therapists and Physical Therapist Assistants (R5-40-PT/PTA) Section 7.1*. Under these regulations, if a patient seeks or receives treatment from a Physical Therapist without a referral from a doctor of medicine, osteopathy, dentistry, podiatry or chiropractic, the patient must consent to the treatment. Additionally, the patient must be referred to one of the practitioners listed above within 90 days after the treatment has commenced. However, a Physical Therapist shall not be required to make such a referral after treatment has concluded.

If you are concerned about the procedures used in your treatment, or about the results of those procedures, we encourage you to discuss your concerns with your Physical Therapist.

I have read this disclosure statement and consent to participation in Physical Therapy.

_____ _____

(PATIENT SIGNATURE) (DATE)

University Physical Therapy
Co-payment/Co-insurance & Deductible Information

A co-insurance is a percentage that a patient owes per Physical Therapy visit. A deductible is the amount you have to pay before your insurance provider begins to pay for your care. These amounts are based upon the amount that your insurance reimburses for services. This also depends on your individual treatment and insurance plan.

A co-payment is a fixed amount that a patient owes per physical therapy visit. **It is determined by your insurance company, not the Physical Therapy provider.**

United Health Care Student Resource Insurance has a 10% co-insurance.

United Health Care State Employee has a 20% co-insurance.

Blue Cross Blue Shield and Blue Chip co-pay depends on your individual plan. Call the member services number on the back of your card for specifics.

For all other insurances and out of state insurances call the member service number on your card for details for physical therapy coverage (co-pay, co-insurance, limit of number of visits, in network vs. out of network coverage, deductible)

It is the patient's responsibility to be aware of their co-payment/co-insurance and deductibles.

Invoices will be sent out periodically to the address on file for payment.

For questions contact the Physical Therapy office at (401) 874-2006

I have read and understand my responsibility for payment.

_____ _____

(PATIENT SIGNATURE) (DATE)

UNIVERSITY PHYSICAL THERAPY

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

With my consent, University Physical Therapy:

- ❖ May use and disclose protected health information (PHI) about me to carry out treatment, payment and health operations (TPO). {Please refer to our Notice of Privacy Practices for more complete description of such uses and disclosures}
- ❖ May call my home or other designated location, leave a message on voicemail or in person, or send a text or email in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care.
- ❖ May mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that University Physical Therapy restricts how it uses or discloses my PHI to carry out TPO, however, the clinic is not required to agree to my requested restrictions, but it is bound by this agreement.

I realize that I have the right to review the Notice of Privacy Practices, prior to signing this consent and that I may request a copy of the same. University Physical Therapy reserves the right to revise its Notice of Privacy Practices at any time. The current Notice of Privacy Practices may be obtained by forwarding a written request to University Physical Therapy, 25 West Independence Way, Suite J, Kingston, RI 02281.

By signing this form, I am consenting to University Physical Therapy's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, University Physical Therapy has the right to decline treatment to me.

Other persons to whom I authorize disclosure of my PHI are:

_____

_____

_____ _____ _____

Patient's name Signature of Patient or Legal Guardian Date