



**Patient Registration Information**

Please Print

Full Legal Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 \_\_\_\_\_  
 Address: Street \_\_\_\_\_ Apartment # \_\_\_\_\_ Home Phone Number \_\_\_\_\_  
 \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Mobile Phone Number \_\_\_\_\_  
 \_\_\_\_\_  
 Male Female \_\_\_\_\_ / / \_\_\_\_\_ Single Married \_\_\_\_\_ (circle one) Date Of Birth (circle one) Name of Spouse \_\_\_\_\_ Spouse Phone Number \_\_\_\_\_  
 Occupation \_\_\_\_\_ (circle one) School Name if student \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone Number \_\_\_\_\_  
 Email Address \_\_\_\_\_ How were you referred to Rehab Plus \_\_\_\_\_  
 Is your injury the result of an accident? **No** **Yes** If yes, was it **work related** **motor vehicle accident** **Other:** \_\_\_\_\_  
 (circle one) (circle one)

**Insurance Information**

Insurance Company \_\_\_\_\_ ( ) Ins Co Phone Number \_\_\_\_\_ Policy ID Number \_\_\_\_\_ Group Number \_\_\_\_\_  
 Policy Holder's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**Worker's Compensation Information**

Worker's Compensation Carrier Address: Street \_\_\_\_\_ City, State Zip \_\_\_\_\_  
 Claim Number \_\_\_\_\_ Case Manager \_\_\_\_\_ Case Manager Phone # \_\_\_\_\_  
 \_\_\_\_\_  
 Date of Injury \_\_\_\_\_ Employer at time of injury \_\_\_\_\_ Employer Phone Number \_\_\_\_\_

**RELEASE OF INFORMATION**

I give permission to Jeff Kitchen, Inc. (Rehab Plus) to release information to my insurance company, attorney, assignees, and/or beneficiaries.

**ASSIGNMENT OF BENEFITS**

I authorize payment directly to Jeff Kitchen, Inc for services I receive. Any payments made to me by third party payer services provided by Jeff Kitchen, Inc will be immediately (within 5 days) transferred to Jeff Kitchen, Inc.

**PAYMENT GUARANTEE**

In consideration of the services rendered and to be rendered to the above named patient by Jeff Kitchen, Inc expressly guarantee payment of this account and agree to pay any charges left unpaid in whole or in part by the insurance company. Should this account proceed to collection agency or court, I will be responsible for both the cost of billed services, as well as cost of collections and any and all attorney and court fees associated with the collection process. The patient is ultimately responsible for account totals and balances. A \$10 processing fee is applied for each subsequently mailed statement.

Signature of Responsible Party or Legal Guardian If Minor \_\_\_\_\_ Date \_\_\_\_\_

By signing above, you, as the patient or legal guardian, agree to the terms and conditions listed under "Release of Information", Assignment of Benefits", and "Payment Guarantee". **Any unilateral alteration, strikeover or modification to the preprinted text or line entries of this document and legal agreement shall be of no effect whatsoever, and at Jeff Kitchen Inc.'s sole discretion, may render this document invalid.**



### Patient Medical History Form

Name \_\_\_\_\_ Age \_\_\_\_\_

Occupation \_\_\_\_\_

Type of work, examples: lifting, prolonged sitting, standing, etc.

Injury/Reason you are here? \_\_\_\_\_

If you had surgery for this injury, what was the date of surgery? \_\_\_\_\_

#### **Past Medical History:**

Do you have any previous history of:

- |               |  |                         |  |   |  |
|---------------|--|-------------------------|--|---|--|
| Diabetes      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pulmonary Disease       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pacemaker     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood Pressure Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Seizures      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Knee Surgery            | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> None Significant |  |
| Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Back Surgery            | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Other _____      |  |

Which of the following aggravates your condition?

- |                                   |                                  |  |                                       |   |
|-----------------------------------|----------------------------------|--|---------------------------------------|---|
| <input type="checkbox"/> Walking  | <input type="checkbox"/> Bending | <input type="checkbox"/> Change of Direction | <input type="checkbox"/> Lying Prone  | <input type="checkbox"/> Overhead Activities  |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Lifting | <input type="checkbox"/> Up Stairs           | <input type="checkbox"/> Lying Supine | <input type="checkbox"/> Impinging Positions  |
| <input type="checkbox"/> Sitting  | <input type="checkbox"/> Running | <input type="checkbox"/> Down Stairs         | <input type="checkbox"/> Sidelying    | <input type="checkbox"/> Prolonged Immobility |

What eases your symptoms?

- |                                     |                                     |  |                                      |
|-------------------------------------|-------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Resting    | <input type="checkbox"/> Medication | <input type="checkbox"/> Supine with feet elevated   | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Avoidance  | <input type="checkbox"/> Walking    | <input type="checkbox"/> Frequent change of position |                                      |
| <input type="checkbox"/> Modalities | <input type="checkbox"/> Standing   | <input type="checkbox"/> None                        |                                      |

Have you been admitted to the hospital or had any surgical procedures during the last 5 years:  Yes  No

What was this condition? \_\_\_\_\_

Is this condition the reason you were referred to physical therapy?  Yes  No

Have you received any physical therapy treatments during the past 5 years?  Yes  No

If yes, for what condition and was the treatment effective? \_\_\_\_\_

Have you had any other previous medical problems or surgeries?  Yes  No

If yes, please specify: \_\_\_\_\_

Did you receive any special tests while in the hospital or as an out-patient? Example: CAT Scan, EMG, EKG, MRI

Yes  No If yes, please specify: \_\_\_\_\_

Have you had any previous orthopedic problems?  Yes  No

If yes, please specify: \_\_\_\_\_

Medications? What type and what for? \_\_\_\_\_

Exercise/Activity level: \_\_\_\_\_ 0 days/week \_\_\_\_\_ 1-2 days/week \_\_\_\_\_ 3-5 days/week \_\_\_\_\_ 6-7 days/week

What types of activities? \_\_\_\_\_

Name of your orthopedic and/or primary doctor? \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

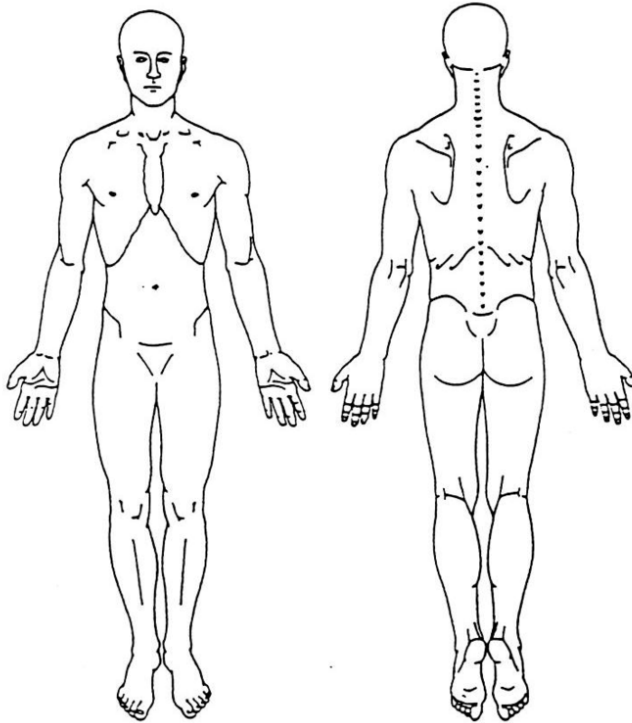
\_\_\_\_\_  
Date

**BODY DIAGRAM**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Please indicate with "xxx" on the chart below where your pain typically presents:



On a scale of 1 to 10, (1 being minimal pain and 10 being excruciating), please rate your overall pain:

At worst: \_\_\_\_\_

At best: \_\_\_\_\_

On average: \_\_\_\_\_

Please indicate the date of your current injury: \_\_\_\_\_

*If uncertain, approximate please*



**Jeff Kitchen, Inc.  
Rehab Plus Sport Therapy**

**Financial Policy and Patient Responsibility  
Acknowledgement of Receipt of Notice of Privacy Practices**

*Rehab Plus Sport Therapy is committed to providing our patients with the highest quality care.  
We thank you for taking the time to read and understand our policy.*

**It is the Patients Responsibility:**

- To know their insurance policy. Patients should be aware of their benefit coverage including which healthcare providers are contracted with their plan, covered and non-covered benefits, authorization requirements, and cost share information such as deductibles, co-insurance, and co-payments. If you are not familiar with your plan coverage, we recommend you contact your carrier directly.
- To obtain a referral from their Primary Care Physician (PCP) and/or obtain authorization for treatment from their insurance carrier prior to receiving services. Any non-covered services are the financial responsibility of the patient.
- To pay their co-payment at the time of service.
- To pay any deductible and co-insurance amounts at the time of service or complete an automatic credit card billing form.
- To promptly pay any patient responsibility indicated by their insurance carrier. If payment of that balance is not received within 30 days, **we will charge a \$10 processing fee for each subsequently mailed statement.**
- To facilitate in claims payment by contacting their insurance carrier when claims have not been paid.
- To schedule all therapy appointments one week in advance and to attend all appointments and follow home instruction. Please be aware your appointments may be scheduled any day of the week (Mon-Fri) and do not have to be set in a specific pattern. (i.e. Mon-Wed-Fri)
- To notify staff in advance of Physician appointments.

**CANCELLATION POLICY:**

- 24 hours notice is required for cancelling or rescheduling a scheduled visit.
- If cancelling the appointment and without such notice, the patient **will be charged \$50.00.**
- A credit card will be kept on file and required for ALL patients.

\_\_\_\_\_  
*Patient Signature accepting Patient' Responsibilities & cancellation policy*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
*Date*

**It is Rehab Plus Sport Therapy's Responsibility:**

- To provide quality medical care.
- To file insurance claims as a courtesy to the patient. Claims are filed twice per month (middle and end of month). Patient statements are sent out in the first week of each month. A 60 day period will be extended for pending insurance payment, after which the patient may be held responsible for the balance.

**Financial Policy Acknowledgement and Assignment of Benefits:**

I have read and understand the above financial policy. I understand that, regardless of my insurance claim status or absence of insurance coverage, I am ultimately responsible for the balance on my account for any services rendered. I also authorize my insurance carrier(s) to make payment directly to Rehab Plus Sport Therapy (Jeff Kitchen, Inc.). Any payments made to me by third party payer services provided by Rehab Plus Sport Therapy (Jeff Kitchen, Inc.) will be immediately (within 5 days) transferred to Rehab Plus Sport Therapy (Jeff Kitchen, Inc.).

\_\_\_\_\_  
*Patient or Responsible Party Signature*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
*Date*

**Acknowledgement of Receipt of Notice of Privacy Practices**

I acknowledge receipt of HIPAA compliant *Notice of Privacy Practices*.

\_\_\_\_\_  
*Patient or Responsible Party Signature*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
*Date*

By signing above, you, as the patient or responsible party, agree to the terms and conditions listed under "Financial Policy Acknowledgement" and "Release of Medical Information and Assignment of Benefits". **Any unilateral alteration, strikeover or modification to the preprinted text or line entries of this document and legal agreement shall be of no effect whatsoever, and at Jeff Kitchen Inc.'s sole discretion, may render this document invalid.**