PATIENT EXPRESS REGISTRSTION *DATE: / /*

1. PATIENT INFO.

_____

LAST NAME FIRST NAME M AGE M/F

_____

STREET ADDRESS CITY ZIP

(_____)_____(_____)_____

HOME PHONE CELL PHONE EMAIL ADDRESS

_____(_____)_____

OCCUPATION EMPLOYER WORK PHONE

_____/_____/_____

SSN# DOB MARTIAL STATUS **IF A MINOR, PARENT SIGNATURE**

_____(_____)_____

EMERGENCY CONTACT PHONE RELATION TO PATIENT

2. MY INSURANCE

_____

PRIMARY INSURANCE CARRIER MEMBER ID GROUP NO

_____/_____/_____

NAME OF INSURED DOB SSN#

_____(_____)_____

RELATIONSHIP TO INSURED PHONE ADDRESS (IF DIFFERENT FROM PATIENT)

_____

SECOND INSURANCE MEMBER ID GROUP NO

_____

3. PAYMENT INFO

I AM PAYING TODAY BY…

☐ CASH, CHECK, OR CREDIT CARD

☐ **INSURANCE,** I WILL ASIGN MY BENEFITS TO YOU BY COMPLETING THE **"ASSIGNMENT OF BENEFITS"** FORM.
MY CO-PAY IS $_____ MY CO-INSURANCE AMOUNT IS $_____ MY DEDUCTIBLE IS $_____

☐ **ATTORNEY** AND I WOULD LIKE TO… ___ GET A 30% DISCOUNT BY PAYING UP FRONT. I'LL GET REIMBURSED AFTER MY CASE SETTLES.___ WAIT UNTIL MY CASE SETTLES, I WILL COMPLETE THE **"ATTORNEY LEIN"** FORM.

MEDICAL INFORMATION

ID#

What is the problem for which you need therapy? _____

Referring Physician: _____ Family Physician: _____

Whom can we thank for this referral? _____ ☐ Website ☐ Yellow Pages ☐ Other _____

Is treatment result of surgery? ☐ Yes ☐ No If yes, please give surgery date _____

Is treatment result of injury? ☐ Yes ☐ No If yes, was injury on the job? ☐ Yes ☐ No Auto Accident? ☐ Yes ☐ No

If treatment is result of injury please give injury date _____

Please check previous medical history:

☐ Arthritis
☐ Cancer
☐ Degenerative Joint Disease
☐ Diabetes
☐ Hepatitis (Type_____)
☐ Mental Illness
☐ Stroke
☐ Other: _____
☐ Blood Disease
☐ Circulation
☐ Depression
☐ Heart Problems
☐ High Blood Pressure
☐ Respiratory / Lung
☐ Tuberculosis

Please list your current medications **with dosages** (Include prescriptions, over-the-counter, herbals & nutritional supplements):

_____
_____
_____
_____
_____
_____

Please list any previous surgeries with dates:

_____
_____
_____

Please list allergies to medications of any kind:

_____
_____
_____

DATE: INITIAL:

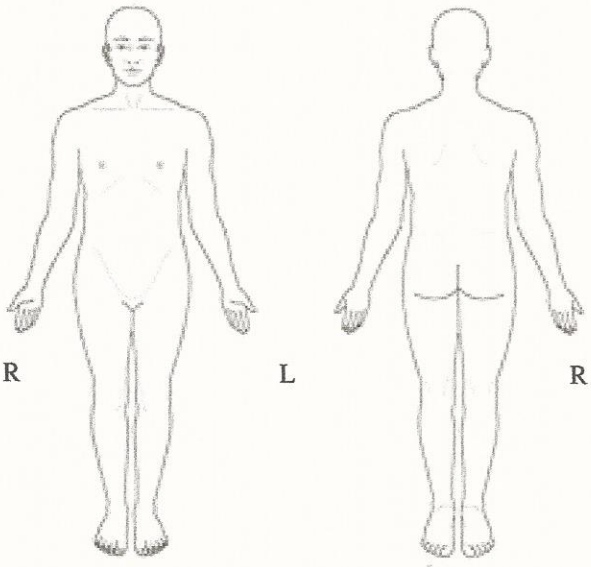
PAIN PROFILE

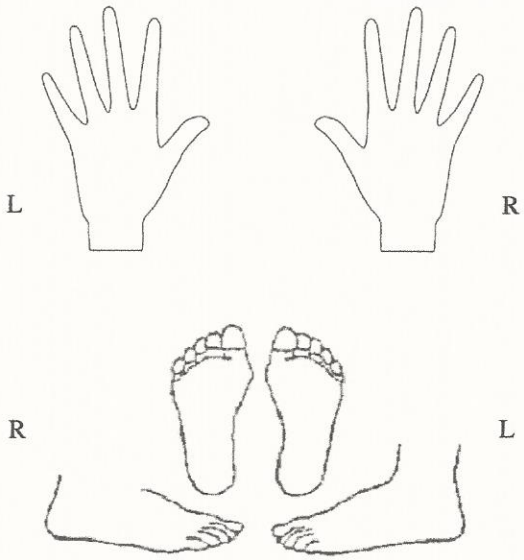
Using the symbols below, please mark the areas you are having discomfort:

Aching
xxxxxx

Burning
//////////

Numbness
000000000





Please rate your pain using the following scale:

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain		Moderate Pain		Distressed Pain		Severe Pain		Very Severe Pain	Excruciating Pain

Consent for Treatment and Uses of Healthcare Information for Purpose of Payment and Healthcare Operations (Assignment of Benefits)

I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician may be considered necessary or advisable while a patient at Corpus Christi Physical Therapy and Sports Medicine. I consent to the release to and, use by, or disclosure of my protected health information to and by CCPT, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of CCPT. I understand that diagnosis or treatment of me by Lee Glover PT, OCS, COMT, and his associates, may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment payment or healthcare operations of the practice. Any and all protected health care information may be disclosed at any time to: _____ whose relationship to me is _____.

CCPT is not required to agree to the restrictions that I may request. However, if CCPT agrees to a restriction that I request, the restriction is binding on CCPT. I have the right to revoke any and all consent, in writing, at any time, except to the extent that CCPT has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from and created or received by my physician, another health care provider, and health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that CCPT will bill my insurance as courtesy to me and any payment disputes are between me and my insurance company. I authorize my insurance company to pay directly to CCPT, all benefits due me under the provisions of my policy. I understand and accept that, although I may be covered by insurance, I am personally responsible for all charges incurred for services rendered to me. I accept liability for all charges not paid by my insurance, third party or other sources.

_____	_____	_____
Print Name	Signature of Patient or Guardian	Date

ACKOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE

I understand I have a right to review CCPT's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the type of uses and disclosure of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of CCPT.

The Notice of Privacy Practices for CCPT is also provided at the reception desk in the office of CCPT. This Notice of Privacy Practices also describes my rights and CCPT's duties with respect to my protected health information. CCPT reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____	_____	_____
Print Name of Patient	Signature of patient or Guardian	Date