



900 Stanhope Gardens, Suite 101 Chesapeake, VA 23320
 Phone: 757.842.6562 Fax: 757.842.6563 www.RPTwellness.com

New Patient Registration

Name _____ Home # _____ Cell # _____

DOB _____ Social Security # _____ Email _____

I give permission to contact me via email for appointments, general questions, and clinic news and updates.

Patient's Address _____ City _____ State _____ Zip _____

Employment _____ Occupation _____

Who is your Primary Care Physician? _____ Phone Number _____

Which Doctor referred you to RPT? _____ Phone Number _____

How did you hear about Restorative Physical Therapy? _____

Emergency Contact _____ Phone _____ Relationship _____

Spouse or Legal Guardian

Name _____ Relationship _____ Email _____

Home Phone _____ Cell Phone _____ Work _____

Patient's Address _____ City _____ State _____ Zip _____

Employment _____ Occupation _____

Injury

Related to an accident or injury? Yes No Date of injury _____ Nature of injury _____

Is this related to an auto accident? Yes No Date of accident _____ State of accident _____

Is there an attorney involved? Yes No Name _____ Phone _____

Is this injury relation to a Workers Compensation case? Yes No Date of Injury _____ File Number _____

Workers Compensation Carrier _____ Phone Number _____

Point of Contact _____

Insurance

	Primary	Secondary
Insurance Name		
Member ID Number		
Subscriber Name		
Relationship to Subscriber		
Subscriber SSN		
Subscriber Date of Birth		

Patient Signature _____ Date: _____

Guardian Signature: _____ Date: _____

Health Intake Form

Patient Name: _____ DOB: _____ Date: _____
Height: _____ Weight: _____ Age: _____

Please complete the following information in detail. This will assist us in designing the most effective and efficient individualized program for you. Every item is significant. Please print neatly.

Who recommended you to this clinic?

Official Diagnosis/Main Problem:

List main complaints/challenges in order of importance:

When did pain begin (weeks/months/years)?:

Describe current area of pain AND type of pain (aching, numbness, tingling, burning): _____

What makes pain worsen?

What makes pain decrease?

Special tests (X-rays, MRIs, etc.):

Current medications/dosages, over the counter medicines, vitamins/supplements: _____

Are you currently receiving occupational or speech therapy, chiropractic care, or home health care?: _____

Surgeries: _____

Injuries: _____

Major/Minor Illnesses: _____

Any history of falls in the last year?: _____

Present Activity
How many hours do you sleep at night?: _____

How many hours per day do you spend in bed?: _____

How would you rate your present level of activity?:
€ Poor € Fair € Good

Please list your present hobbies: _____

Current Work Status and History
Please state what you do for a living: _____

How many hours do you work per week?: _____

If not working, how long have you not worked?: _____

Do you receive compensation (disability insurance)?: Yes No

If not, are you considering or have you applied for compensation of any kind?: _____

If you anticipate returning to work, when do you hope to do so?: _____

Home Environment
Please list any current assistive devices (cane, walker, etc): _____

Present home environment (railings, ramps, bathroom modifications, etc): _____

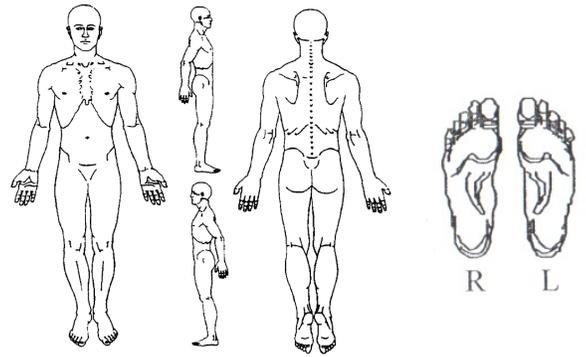
Are you losing weight without trying: Yes No

Are you coughing up blood/noticing it in urine/stool: Yes No

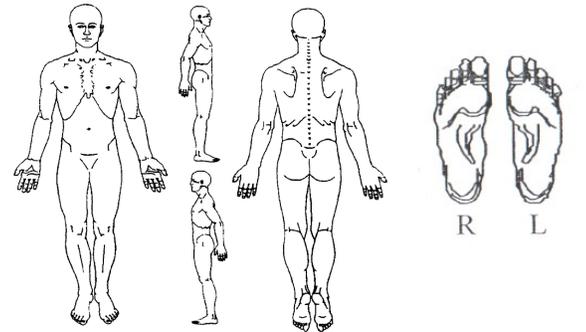
Circle the level of pain you are experiencing (1=lowest):

1 2 3 4 5 6 7 8 9 10

Pain Diagram: please shade all areas of pain



Parasthesia Diagram: Please shade areas of "funny feeling" (tingling, burning, pins and needles, etc)



Health Habits

€ Tobacco € Alcohol € Caffeine € Soda

How often do exercise per week: _____

What type of activities do you do for exercise: _____

Nutrition and Diet:

Any specific diet/food allergies? _____

Circle the level of stress you are experiencing (1=lowest)

1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (changes in job/residence, finances, legal problems):

While you are here at Restorative Physical Therapy a goal list will help us recognize what you would like to accomplish. Your therapist will evaluate you with your input in mind.

Goals will be revised as needed. Please fill in the blanks below, answering the question

below, answering the question

"I know I will be better when I can...."

1. _____
2. _____
3. _____

<ul style="list-style-type: none"> ○ Alcoholism ○ Allergies ○ Alzheimer's Disease ○ Arthritis ○ Asthma ○ Attention Deficit Disorder (ADD) ○ Attention Deficit Hyperactivity Disorder (ADHD) ○ Autoimmune Disease type _____ ○ Back Pain ○ Bronchitis ○ Cancer type _____ ○ Carpal Tunnel Syndrome ○ Cerebral Palsy ○ Cholesterol (elevated) ○ Chronic Fatigue Syndrome ○ Circulatory Problems ○ Colitis ○ Dental Problems ○ Depression ○ Diabetes ○ Diverticular Disease ○ Drug Addiction ○ Eating Disorder ○ Epilepsy ○ Environmental Sensitivities ○ Eyes/ears/nose/throat problems ○ Facial Palsy ○ Fibromyalgia 	<ul style="list-style-type: none"> ○ Food Intolerance ○ Gastrointestinal Problems ○ Genetic Disorder type _____ ○ Glaucoma ○ Gout ○ Headaches ○ Heart Disease ○ High Blood Pressure ○ Infection, chronic ○ Inflammatory Bowel Disease ○ Irritable Bowel Syndrome ○ Kidney or bladder disease ○ Learning disabilities ○ Liver or gallbladder disease (stones) ○ Lymphedema ○ Lymphatic Problems ○ Mental Illness ○ Intellectual Disabilities ○ Migraine Headaches ○ Mononucleosis ○ Multiple Sclerosis ○ Musculoskeletal problems ○ Obesity ○ Osteoporosis ○ Paraplegia ○ Parkinson's ○ Phobias ○ Pneumonia ○ Quadriplegia ○ Respiratory problems ○ Rheumatoid Arthritis 	<ul style="list-style-type: none"> ○ Seasonal Affective Disorder ○ Sinus Problems ○ Skin Problems ○ Spina Bifida ○ Stroke ○ Thyroid Disease/Trouble ○ Traumatic Brain Injury (TBI) ○ Tuberculosis ○ Ulcer ○ Urinary Tract Infection ○ Varicose Veins ○ Other Medical (Men): ○ Benign Prostatic Hypertrophy ○ Decreased sex drive ○ Infertility ○ Prostate Cancer ○ Sexually Transmitted Disease ○ Other _____ Medical (Women): ○ Breast Cancer ○ Breast surgery ○ Decreased sex drive ○ Endometriosis ○ Fibrocystic breasts ○ Fibroids/ovarian cysts ○ Infertility ○ Menstrual irregularities ○ Pelvic Inflammatory Disease ○ PMS ○ Sexually Transmitted Disease ○ Vaginal Infections ○ Other
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AUTHORIZATION FOR TREATMENT

I hereby authorize evaluation and treatment by Restorative Physical Therapy on behalf of myself and/or my minor children, including stepchildren.

RELEASE OF INFORMATION

I hereby authorize the release of any and all medical and/or changes information as is necessary for third party reimbursement from any insurance payer or government agency involved in the payment of my treatment.

OBLIGATION OF PAYMENT

I direct and assign payment from my insurance company to Restorative Physical Therapy. I understand that I am ultimately responsible for payment of the entire bill for medical goods or services provided to my children or me and that my insurance policy is a contract between my insurance company and me. I shall pay any deductible and/or co-payment at the time of service. This amount is an estimate of the portion of the fee that is not covered by insurance.

I will advise Restorative Physical Therapy immediately of any changes in insurance coverage or my address.

If I am choosing to seek physical therapy from Restorative Physical Therapy as an out-of-network provider, I will be given the option of a self pay fee of \$105 . We accept cash/credit/check payment.

PAST DUE BALANCES AND PROCEDURES FOR COLLECTION

If payment from my insurance company is not received within 90 days, my account will be due and payable in full by me. Any balance remaining on the account after insurance pays will be due upon receipt of my statement. If a self pay client (i.e. RPT does not take my insurance or my insurance benefits for P.T. are capped out for the year), I will pay the amount in full at time of appointment.

If prompt payment is not made, I understand that Restorative Physical Therapy may immediately take action to collect its charges and any outstanding balance. I agree to pay all costs and expenses incurred by Restorative Physical Therapy for collecting any amounts I owe, including court costs and thirty-three and one third percent attorney fees of any outstanding balance. Additionally, I understand that a fee of \$25.00 will be applied to my account for any returned checks.

CELL PHONE USE POLICY

At Restorative Physical Therapy, our patients are at the center of everything we do. Among our many priorities, we value and respect the privacy of our patients, our visitors, and our staff. Patients and visitors are welcome to use personal devices in the lobby and outside the practice. No cell phone use is permitted in the treatment area or in treatment rooms. We appreciate your cooperation and ask you to follow them while at RPT.

Please be considerate of those around you when using your mobile devices. Remember that others may overhear your conversations and that you may not have an expectation of privacy. Use low, quiet voices, and do not act in a disruptive or disrespectful manner.

ACKNOWLEDGEMENTS

I, the Patient/Guardian, acknowledge that I was given an opportunity to ask questions about the information provided in this form. My signature is acknowledgment of my understanding of and agreement with the provision of this agreement.

Patient/Guarantor signature: _____ Date: _____

Witness signature: _____ Date: _____



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Attendance Policy

Dear Valued Patient:

Please be aware of the following attendance policy created to best serve you and all of our patients. We look forward to providing quality care for you, and to aid in maximizing benefits from therapy, we need your full participation.

1. Please arrive on time for your scheduled appointment. Please call if you will be more than 10 minutes late. If you are more than **15 minutes** late for your appointment, we may be required to reschedule.
2. Please call 24 hours in advance if you know you have to cancel an appointment. We understand emergencies do happen, so in these instances please call as soon as possible to cancel your appointment.
Restorative Physical Therapy reserves the right to assess a \$95.00 fee for cancellations with less than 24 hours notification and a \$95.00 fee for all no shows to our office.
3. We will have to remove you from our schedule after 3 consecutive cancellations or 2 “no-shows.” This may require you to return to the doctor before coming back to therapy. Your doctor will be made aware of cancellations and “no-shows.”
4. We are generally flexible with our ability to reschedule appointments. Please call us as soon as you know that you have a conflict in your schedule and we will try our best to accommodate your needs.
5. Physical therapy is covered under medical necessity on most insurance policies and therefore we must see you **on a weekly basis**. If you are unable to abide by this policy then we will have to remove you from our schedule.

Acknowledgement of receipt of Notice of Privacy Practices

By default, no other persons may have access to my medical records except the following people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize RPT to contact me, and leave messages, regarding my Physical Therapy care and/or appointments on the following numbers:

Home: _____ Cell: _____ Work: _____

I have read and understand the above attendance policy and Privacy Practices were reviewed.

Signature: _____ Date: _____