PATIENT REGISTRATION FORM

Patient Number:_____
(Office Use Only)

REASON FOR VISIT:

_____

PATIENT INFORMATION

Name: _____
First MI Last

Primary Phone: _____ Alternate Phone: _____

Mailing Address: _____
City: _____State: _____Zip: _____

E-Mail Address: _____

Social Security Number: _____

Date of Birth: _____Age: _____ Sex: ☐ M ☐ F

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Primary Care Physician: _____ Phone: _____

GUARANTOR INFORMATION (Person responsible for bills, if other than patient. *REQUIRED for patients under age 18*)

Guarantor Name: _____
First MI Last

Guarantor Date of Birth: _____Relationship to Patient: _____=

Guarantor Social Security#: _____Guarantor Telephone: _____

Guarantor Address: _____

INSURANCE INFORMATION

Primary Insurance:_____ID Number:_____

Policy Holder's Name: _____SUBSCRIBER'S DOB: _____

Secondary Insurance: _____ID Number: _____

Policy Holder's Name: _____ SUBSCRIBER: _____

EMERGENCY CONTACT

Emergency Contact Name: _____Phone: _____

Relationship to Patient: _____Address: _____

DESIGNATED PERSON TO DISCUSS MEDICAL CARE WITH: _____

Continued on following page….

HEALTH HISTORY QUESTIONNAIRE

Name:_____

First MI Last

Height: _____ Weight: _____

Do you use tobacco? ☐ Yes ☐ No If yes, describe:_____

Do you use alcohol? ☐ Yes ☐ No If yes, describe:_____

Have you ever been treated for substance abuse? ☐ Yes ☐ No If yes, describe:_____

_____

When is your next appointment to your referring physician?_____

Are you presently off work due to your current condition? ☐ Yes ☐ No

List all medications you are currently taking:_____

_____

_____

_____

List all operations you have had, including the date and any complications: _____

_____

_____

_____

Explain any other health history you feel may be important in your care (for example, allergies, pacemaker, pregnancy, etc.):

_____

_____

_____

MOTOR VEHICLE ACCIDENT INFORMATION (Fill out if your Injury is Related to an Auto Accident)

Nature of Accident_____Date of Accident_____

Attorney Name:_____Attorney Phone:_____

Attorney Address: _____Attorney Fax: _____

I acknowledge that I have received a copy or seen the "Consent for Treatment" and "Notice of Privacy Rights". I understand that I may ask questions about either notice at any time.

I affirm the accuracy of the information provided above.

Sign: _____ Date: _____

BRIDGEPORT PHYSICAL THERAPY SERVICES, INC.

APPOINTMENT POLICY

I understand that my doctor may have prescribed therapy for me and that physical therapy is an ongoing process, which requires regular attendance to be optimally effective. I understand that if I am late for an appointment, I may need to reschedule or may have to accept an abbreviated treatment for that day. I understand that if I cancel or no-show for three consecutive appointments, BPTS has the right to discharge me from care for being non-compliant with my physicians' orders or therapist plan of care.

CONSENT FOR TREATMENT

You are being seen at Bridgeport Physical Therapy Services, Inc., by one of the following Physical Therapists: Jack Spatafore, Christa Randolph, Bobbi Jo Ridenour, Lawren Sandy, Samuel Aloi, Andrew Spatafore, Occupational Therapist: Julie Harbert, and/or one of the following Physical Therapy Assistants: Kim Gear, Jessica Hall, Grant Burton, Andrea Reppert, Nathaniel Jones, Sarah Butcher. We occasionally have student interns who may provide evaluation and treatment under the direct supervision of Physical Therapists. You have the right to refuse treatment by an intern by advising the staff of your decision. The information listed below is required to ensure prompt, quality care. **Please read:**

To ensure prompt, quality care it is your responsibility to:

1. Supply us with a physician's referral, insurance claim information, release forms, etc., to ensure proper billing.
2. Make sure we have updated physician referrals (every 30 days for Medicare), insurance approval, workers compensation approval, etc., as needed.
3. Give us correct information regarding your problem so that we may properly assess you and develop a plan for treating you as well as giving us continuing information regarding your status.
4. Ask any questions you may have regarding your treatment.
5. Stop at the appointment desk to schedule subsequent appointments.
6. Inform us as soon as possible if you need to cancel an appointment.
7. Follow any home regimen prescribed, within tolerance levels, or inform us if you do not. Failure to follow home programs may hinder your progress.
8. Inform us in advance of upcoming physician's appointments so we may prepare a progress evaluation for your physician.
9. Inform us of any medical conditions that may affect your treatment options, such as pregnancy, diabetes, pacemakers, high blood pressure, carcinoma and / or any blood born infectious diseases so that appropriate precautionary measures may be taken.
10. Inform us if you wish to discontinue treatment and your reasons for doing so.

It is our responsibility to:

1. Collect information for billing and assessment purposes.
2. Provide treatment as promptly as possible.
3. Answer any question you have regarding your treatment.
4. Submit progress reports to your physician, workers compensation, insurance company, attorney, etc., as needed.
5. To discontinue treatments if progress is no longer being made or if you have reached maximum benefit.

You will receive treatment based on an assessment of your problem. Treatment may include, but not be limited to, evaluation, moist heat, ice, exercises, aquatic therapy, myofascial release, stretches, traction, ultrasound, iontophoresis and bracing. Not all treatment options are covered by all payers. You may be given the option of paying out of pocket for items such as tape or braces if your insurance carrier deems these are not a covered benefit. Your treatment will be designed to achieve maximum benefit and may be changed as indicated. In general, physical therapy interventions are very safe and there is very little chance of injury. The most common complaints are of muscle soreness after exercises. It is very important for you to let us know of any discomfort during treatment so that we may change or modify treatment as necessary. Feel free to ask any specified questions you may have regarding your treatment. You have the right to be involved in your care and may choose not to receive specific treatment or to defer any treatment at any time by informing us of your wishes. If I am injured or harmed in any way during my treatment at Bridgeport Physical Therapy Services in the gym or pool area while receiving assistance from my caregiver, I will not hold Bridgeport Physical Therapy Services responsible or liable if this occurs during, but not limited to, dressing, undressing, toileting or showering. I have read and understand the above statements. I understand that I have a right to know the nature of proposed treatment, the benefits of the proposed treatment, the most common risk associated with proposed treatment and reasonable alternatives to such proposed treatment. I understand that I have a right to choose where I want to receive treatment.

Revised02/14/01-5/12/16, 4/10/2017, 10/3/2018 03/09/2021, 10/19/2022, 10/17/2023, 8/26/24