GENESIS PHYSICAL THERAPY GROUP Patient Registration

Today's Date

How did you first hear about us?

○ Facebook/Social Media ○ Location ○ Friend/Family ○ Insurance
○ Google/Search Engine ○ Other ○ Doctor/Physician

First Name **Middle Init** **Last Name** **Date of Birth**

Gender

○ Male ○ Female ○ Other ○ Prefer not to answer

Marital Status

○ Single ○ Married ○ Divorced ○ Widowed ○ Other

Mailing Address **Apt #** **City** **State** **Zip**

Best Phone #

Phone Type

○ Home ○ Cell
○ Work ○ Other

Other Phone #

Phone Type

○ Home ○ Cell
○ Work ○ Other

Email Address

Social Security Number

Emergency Contact Name

Emergency Contact Phone #

PRIMARY INSURANCE INFORMATION

PRIMARY Insurance Company

Subsciber ID/Policy #

Subscriber Name

Subscriber DOB

Relationship ○ Self ○ Spouse ○ Child ○ Mother ○ Father ○ Other

SECONDARY INSURANCE INFORMATION

SECONDARY Insurance Company

Subsciber ID/Policy #

Subscriber Name

Subscriber DOB

Relationship ○ Self ○ Spouse ○ Child ○ Mother ○ Father ○ Other

TEXT MESSAGE COMMUNICATION CONSENT

Cell Phone # (If no cell #, enter 0s)

Text Message Communication

◯ Opt-In to receive text message communication

◯ Opt-Out to decline

I authorize Genesis Physical Therapy to send text message communications to me on my provided cell phone number. I understand that I may reply with various commands to receive account information such as balances, future appointments, office location and other alerts. I understand that text messaging is not a secure format of communication. There is some risk that individually identifiable health information or other sensitive or confidential information contained in such text may be misdirected or intercepted. Information included in text messages may include your first name, date/time of appointments, name of physician, and physician phone number, or other pertinent information. Text message charges from my cell phone provider may apply. By signing below, I indicate I am the person legally responsible for use of cell phone number, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text messaging services. Text message charges from my cell phone provider may apply. I know that I am under no obligation to authorize Genesis Physical Therapy to send me text messages. I may opt-out of receiving these communications at any time by calling the Service Desk @ (601) 898-4324. Please allow 2-3 business days for processing.

SIGN HERE

CONSENTS AND AUTHORIZATIONS

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RELEASE OF MEDICAL TREATMENT: The undersigned authorizes Genesis Physical Therapy to release the Patient's health information as needed to process insurance claims. The undersigned understands Genesis Physical Therapy participates in various insurance programs with insurance carriers and may be required to submit the Patient's health information to the Patient's insurance carrier. PAY BENEFIT CLAIMS: The undersigned assigns payment directly to Genesis Physical Therapy for all insurance and similar benefits otherwise payable to the Patient by virtue of medical treatment provided by Genesis Physical Therapy, but not to exceed regular charges for medical treatment. The undersigned understands the Patient is financially responsible for charges not covered by insurance and agrees that the Patient shall be responsible for all charges incurred, regardless of the status of medical insurance or similar benefits. CONSENT FOR TREATMENT: The undersigned authorizes and consents Genesis Physical Therapy to furnish medical treatment that the Therapist and/or Physician consider necessary and proper in the treatment of the Patient. In doing so, I understand that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature, including but not limited to areas of my body I may consider sensitive and/or private. PAYMENT TERMS: The undersigned understands that payment in full is due on the date of treatment for all services provided and the undersigned agrees to pay all charges for the Patient. Genesis Physical Therapy does not issue refunds or invoices for debits/credits less than $5.00. After 90 days, balances under $5.00 will be written off and credits under $5.00 will be retained by Genesis Physical Therapy. I acknowledge a $30 fee will be added to my account for returned checks. I understand that if I fail to pay the balance in full within (30) days after the last date of service, a late fee will be added that is the GREATER of five dollars ($5.00) or four percent (4%) of the unpaid balance. I understand that if I fail to pay the balance in full within (30) days after the last date of service, this account can be referred to a collection agency. If I fail to pay any balance in full and am referred to a collection agency or attorney, I agree to pay any cost of collections, attorney fees, and cost of court. VALUABLES: The undersigned hereby releases Genesis Physical Therapy and its employees from any responsibility due to loss or damage of any valuables while on the premises of Genesis Physical Therapy. CANCELLATION / NO SHOW FEE: In an effort to enhance each of your therapy visits, we strongly encourage regular attendance. If it is necessary to cancel your scheduled appointment, we require that you call our office at least 24 hours in advance. Failure to notify our office 24 hours in advance can result in a $35.00 fee. This policy also applies to not showing up for your current and any future scheduled appointments. WORKERS COMPENSATION PATIENTS: Your physician feels that you have a need for therapy, so it is imperative that you come to all of your therapy sessions. In the event you feel you will be unable to keep your scheduled appointment, it is your responsibility to take the following steps: 1) Contact Genesis, 2) Contact your Work Comp Adjuster, 3) Contact your Physician to explain any missed appointments. It is our policy to contact your Physician, Employer, and/or Work Comp Adjuster with explanations of any and all missed appointments. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: Designated Privacy Official: (601) 898-7561.I hereby acknowledge that I have received, reviewed, and understand the Genesis Physical Therapy Notice of Privacy Practices. You may request at any time to receive a copy of this notice for your records. RELEASE OF INFORMATION: Unless otherwise authorized by this document or by law, Genesis Physical Therapy will only release the Patient's health information to the undersigned. The undersigned may specify below to whom the Patient's health information may be released. This information would include but not limited to medical information, billing, and other protected health information.

***I certify that I have read, understand, and agree to the above Consent and Authorizations.**

SIGN HERE

HEALTH HISTORY

Patient Name

Today's Date

Current Weight

Current Height

Primary Care Physician Name

Are you currently employed?

- ◯ No
- ◯ Retired
- ◯ Yes, Name of Employer

Are you employed?

- ◯ Full Time
- ◯ Part Time
- ◯ Seasonal
- ◯ N/A Not Applicable

Current Job Title / Occupation?

Is this injury/pain accident related to?

- ◯ Employment/Work Injury
- ◯ Auto Accident
- ◯ Sports Injury
- ◯ N/A Not Applicable
- ◯ Other (Please Explain)

If Workers' Compensation, who should we contact are your job to obtain claim information?

INCLUDE NAME & PH #

Have you retained an Attorney to represent you for this injury?

- ◯ No
- ◯ Yes, Attorney's Name & Phone #

What side of the body is your injury/pain?

- ◯ Left Side
- ◯ Right Side
- ◯ Both Sides
- ◯ N/A Not Applicable

Date of Injury / Onset Date / Date Pain Started?

Was surgery performed on this injury/pain?

- ◯ No
- ◯ Yes, Date of Surgery/Type of Surgery

Have you been hospitalized within the past 12 months?

- ◯ No
- ◯ Yes, Hospitalization Dates

What happened to cause this injury/pain?

Where did this accident/injury occur? (Ex: work, parking lot, home, street)

Main reason for needing Physical Therapy?

_____

	0=No Pain			5=Moderate Pain					10=Extreme Pain		
	0	1	2	3	4	5	6	7	8	9	10
Pain at WORST	○	○	○	○	○	○	○	○	○	○	○
CURRENT Pain	○	○	○	○	○	○	○	○	○	○	○
Pain at BEST	○	○	○	○	○	○	○	○	○	○	○

Describe your pain (check all that apply)

☐ Burning ☐ Sharp ☐ Dull/Achy ☐ Throbbing ☐ Shooting ☐ Numbness/Tingling
☐ Constant ☐ Intermittent ☐ Worse in AM ☐ Worse in PM ☐ Worse at Night ☐ N/A Not Applicable

Does any of the following aggravate your injury/pain? (check all that apply)

☐ Sitting ☐ Standing ☐ Walking ☐ Stairs-Up ☐ Stairs-Down ☐ Sit to Stand
☐ Bending ☐ Voiding ☐ Lying Down ☐ Cough/Sneeze ☐ N/A Not Applicable

What makes your pain WORSE?

_____

What makes your pain BETTER? (ex: ice, heat, medication, rest)

_____

Have you ever experienced this same injury/pain before?

○ No ○ Yes, Please Explain _____

Rate your general health

○ Good ○ Fair ○ Poor

Social History

○ Lives at Assisted Living Facility ○ Lives with Family ○ Lives with Caregiver
○ Married (lives with spouse) ○ Single (lives alone)

Duty Level

○ Sedentary ○ Light ○ Medium ○ Heavy ○ Very Heavy ○ N/A Not Applicable

Did your physician take you off of work?

○ N/A ○ No ○ Yes, Dates _____

Are you a tobacco user?

○ No ○ Yes

Have you been a patient of Genesis in the past?

○ No ○ Yes, What Year? _____

Are you currently receiving Home Health or Hospice?

○ No ○ Yes

Do you have a history of falls (fallen 2 or more times within the past 12 months)?

◯ No - skip next question ◯ Yes - proceed to next question

What is the main contributing factor for your falls?

◯ Reaction to Medication ◯ Home Fall/Home Fall Hazard ◯ Changes in Blood Pressure

◯ Vision/Vision Problems ◯ Other, Please Explain _____

Mark the medical conditions that apply to you (check all that apply)

☐ NONE
☐ Alzheimer's
☐ Cardiovascular Disease
☐ Cauda Equina Syndrome
☐ C.V.A. / Stroke
☐ Current Infection
☐ Diabetes Type 1
☐ Diabetes Type 2
☐ History of Cancer
☐ High Blood Pressure
☐ Huntington's
☐ Immunosuppression
☐ Lupus
☐ Muscular Dystrophy
☐ Obesity
☐ Other, Please Explain _____
☐ Pacemaker/Defibrillator
☐ Fibromyalgia
☐ Traumatic Brain Injury
☐ Fracture/Suspected Fract
☐ Parkinson's
☐ Rheumatoid Arthritis
☐ Osteoarthritis

List any past surgeries with dates (If you do not know exact date, list year)

_____

Are you currently pregnant?

◯ N/A ◯ No ◯ Yes, Due Date _____

Do you have a diagnosis of Depression or Bipolar Disorder?

◯ No ◯ Yes

Have you had any of the following tests done for this this injury/pain?

☐ N/A-None ☐ X-Ray ☐ MRI ☐ CT Scan ☐ Myelogram ☐ EMG ☐ Test Results: _____

Have you had any Physical, Occupational, Speech, or Chiropractic Therapy for this injury/pain?

◯ No ◯ Yes, Please Explain _____

Have you had any Physical, Occupational, Speech, or Chiropractic Therapy since January 1 of this year?

◯ No ◯ Yes, How Many Visits _____

When is your next appointment with the Physician that sent you here?

_____

Are you currently taking any medications?

◯ No ◯ Yes, List them Below

Medication List - please fill out each section completely

Dosage (ex: 20mg)
Frequency (ex: once per day)
Route (Oral, Injection, Inhalation, Transdermal, Nasal, Eye, Ear)

	Name of Medication	Dosage	Frequency	Route
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				