REGISTRATION FORM

Today's date: | Referring Doctor:

PATIENT INFORMATION

Patient's last name: | First: | Middle: | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No | If not, what is your legal name? | (Former name): | Birth date: / / | Age: | Sex: ❑ M ❑ F

Street address: | Social Security no.: | Home phone no.: ( )

P.O. box: | City: | State: | ZIP Code:

Occupation: | Employer: | Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: | Birth date: / / | Address (if different): | Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation: | Employer: | Employer address: | Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance Medicare] Tricare VA BCBS Medicaid

Workers Comp__________________ Coventry Auto Insurance______________________ ❑ Other

Subscriber's name: | Subscriber's S.S. no.: | Birth date: / / | Group no.: | Policy no.: | Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable): | Subscriber's name: | Group no.: | Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Kebe Cares physical therapy. I understand that I am financially responsible for any balance. I also authorize Kebe Cares Physical Therapy or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Kebe Cares Physical Therapy
Personal Medical History

Name: ______________________________ Date:______________

Do you smoke? Yes/No

Do you participate in physical exercise? Yes/No How often?___________

Have you had any Automobile accident? Yes/No Date: ________ Body area affected__________________

Have you had any injuries related to work? Yes/No Date: _______ Body area affected__________________

Onset of current condition: ___________________

Main Complaints, Restrictions and Pain Alleviations:

____

____

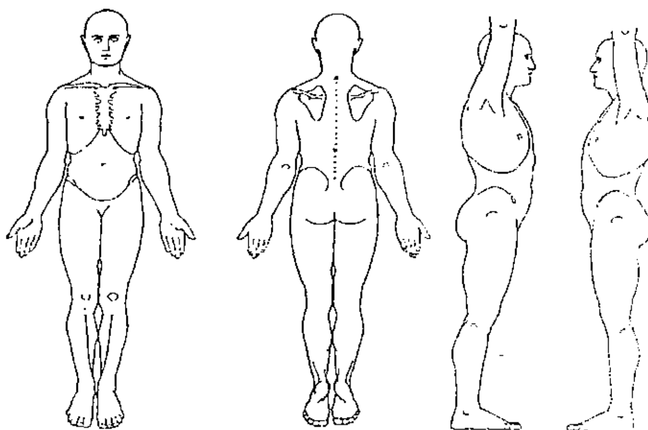
If you are having pain, please rate the severity on a 0-10 scale, where 0 is no pain and 10 is the most severe pain:

At worst:	0	1	2	3	4	5	6	7	8	9	10
Current:	0	1	2	3	4	5	6	7	8	9	10
At best:	0	1	2	3	4	5	6	7	8	9	10

Is the pain constant or Intermittent_____________

Please indicate the location of your sympto

Sharp (**S**), Burning (B), Aching (**A**),Tingling (T)
Numbness (**N**), Others



Medical History:

Please mark if you have ever had any of the followi

Describe:

- ○ Osteoporosis
- ○ Cardiovascular Disease: High Blood Pressure, Heart attack
- ○ Diabetes
- ○ Surgical History and date:____________________
- ○ Other
  - ○ Arthritis ○ Anemia ○ Headaches
  - ○ Nausea or vomiting ○ Head Injury/Concussion
  - ○ Dizziness/light headed ○ Depression
  - ○ Anxiety ○ Hernia ○ Numbness/Tingling
  - ○ Hearing Loss ○ Fibromyalgia ○ Fatigue/Weakness
  - ○ Seizures/Epilepsy ○Thyroid Problems
  - ○ Asthma ○ Shortness of Breath
  - ○ Any other conditions

  Allergies/Skin Sensitivity______________

List ALL **Current Medications:**

Medications	Dosage

Have you ever had any imaging performed? ___ X-Ray ___ MRI ___ CT Scan ___ Doppler ___ Ultrasound

_________________________________ ________________

Patient/Parent/Guardian Signature **Date**

HEALTHCARE PROVIDER NOTES: FOR OFFICIAL USE ONLY

Office Policy

CONSENT FOR CARE & TREATMENT Your physical therapist will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I, the undersigned, do hereby agree and give my consent for Kebe Cares to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.
ASSIGNMENT OF INSURANCE BENEFITS I hereby authorize Kebe CaresPhysical Therapy to furnish Information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.
WORKERS' COMPENSATION CLAIMS If you claim Workers' Compensation benefits and are Subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered you.
CANCELLATION & NO-SHOW POLICY. We require 24 hours notice in the event of a cancellation. The charge for cancellation without proper notice is $30 for physical therapy visits. This charge will not be covered by insurance, but will have to be paid by you personally prior to receiving additional treatment.
FINANCIAL POLICY. We bill your personal insurance carrier solely as a courtesy to you. You Are responsible for your bill. We require that arrangements for payment of your estimated share be made at each visit. If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full from you. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us. If formal collections procedures become necessary, you will be responsible for additional costs incurred. Your insurance benefits as quoted to us by your insurance carrier have been reviewed with you. We assume no liability for any errors made by your insurance carrier in this quotation. We have reviewed these benefits with you and you agree to pay your portion of this bill.
Estimated patient payment / co-pay / deductible amount per visit $_______________
Arrangements for payment of patient's co-pay / deductible amount (circle one)
I will pay each visit *I will pay weekly in advance*
The above information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT. *Kebe Cares Physical Therapy reserves the right to refuse service to anyone.*

Patient / Guardian / Responsible Party Signature:_______________________ **Date:**__________

Clinic Representative:______________________ **Date:**________________

CONSENT FOR TREATMENT OF A MINOR
As parent and/or legal guardian, I authorize Kebe Cares Physical Therapy to treat the minor patient named in the attached forms while I am not present.

Parent / Guardian Signature:_________________________ **Date:**__________

Kebe Cares Physical Therapy

Phone: 910 229 2735 Fax: 910 229 2731

Notice of Patient Privacy

We are committed to preserving the privacy of your personal health information. In fact, we are required by law protect the privacy of your medical information and to provide you with Notice describing:

How Medical Information About You May Be Used And Disclosed
And How You Can Access This Information

We may require your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.
As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.
We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our Notice from time to time. You have the right to receive a copy of our most current Notice in effect. If you have not yet reserved a copy of our current Notice, please ask us and we will provide you with a copy. If you have any questions, concerns, or complaints about the Notice or your medical information, please contact Kebe Cares Physical therapy at 1285 Oliver Street, Fayetteville, NC 28304.

Release of Medical Information Necessary to Process Claims

I authorize the release of all medical or other information needed to process this medical claim. I also request payment of government benefits to the party who accepts assignment below.

Authorization of Payment of Benefits to Provider

I authorize payment of medical benefits to this Health Care Provider for the physical and/or occupational services given to me or dependent.

Consent for Physical Therapy

I, the undersigned due hereby agree and give my consent for Kebe Cares to furnish physical therapy to myself or dependent, which is considered necessary and proper in evaluating and treating myself or dependent for my/their physical condition.

I have read and fully understand the above information.

Patient/Guardian Name: ______________________________
Patient/Guardian Signature:______________________________ **Date:**____________________

KEBE CARES PHYSICAL THERAPY

MEDICATION LIST

Medical record #____________

Name ______________________________ **Date**________________

Example:

	Motrin	*200mg*	*2 times daily*	*by mouth*	*Headache*
	Medication	**Dosage**	**How often**	**How taken**	**Reason for taken**
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					