S★T★A★R
PHYSICAL THERAPY

Patient Registration

A. PATIENT

Account #:

First Name:	Middle Initial:	Last Name:
Address:		
City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:
DOB: <dob>	SSN #:	Gender: ❑ Male ❑ Female
E-MAIL:		To receive **Statements via Email** check here ❑
❑ Exclude from **Appointment Reminders**? *(If box checked you will not receive Appointment Reminders)*		
Employment Status: ❑ Employed ❑ Unemployed ❑ Retired ❑ Student ❑ Disabled ❑ Other:		
Employer Name:		

B. EMERGENCY CONTACT

Relationship to Patient: ❑ Spouse ❑ Parent ❑ Child ❑ Grandparent ❑ Sibling ❑ Friend ❑ Other:		
First Name:	Middle Initial:	Last Name:
Home Phone:	Work Phone:	Cell Phone:
Preferred Contact Method: ❑ Home Phone ❑ Work Phone ❑ Cell Phone		

C. GUARANTOR / RESPONSIBLE PARTY (fill out if patient is a minor)

Relationship to Patient: ❑ Parent ❑ Grandparent ❑ Legal Guardian ❑ Other:		
First Name:	Middle Initial:	Last Name:
Home Phone:	Work Phone:	Cell Phone:

D. ACCIDENT

Was your injury as a result of a Work Related or Auto Accident? ❑Yes ❑No If Yes, ❑Work ❑Auto		
Work Comp or Auto Insurance Name:		
Phone #:	Policy #:	Claim #:
Adjuster Name:	Accident Date:	Accident State:

E. INSURANCE (if applicable)

Primary Insurance: (copy of card must be on file)	**Check here** ❑ if Name, SSN & DOB same as patient.
Insurance Name:	
Subscriber (Insured) Name:	
Relationship of Patient to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other	
SSN #:	**DOB** (mm/dd/yy)
Secondary Insurance: (copy of card must be on file)	**Check here** ❑ if Name, SSN & DOB same as patient.
Insurance Name:	
Subscriber (Insured) Name:	
Relationship of Patient to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other	
SSN #:	**DOB:** (mm/dd/yy)

STAR PHYSICAL THERAPY

Patient Health Questionnaire

Patient Name:	**DOB:**	**Account #:**
Current **employment status**? ❑Occupation ________________________ ❑Retired ❑Student ❑Disabled		

Work activities mostly include *(check all that apply)*

❑ Sitting	❑ Lifting	❑ Use of Computer	❑ Bending
❑ Standing	❑ Walking	❑ Driving	❑ Other

How do you **rate your health**? ❑Excellent ❑Good ❑Fair ❑Poor
When did your **current symptoms begin**? (*date*)_____/_____/_____ or (*time period*) _________________
Have you experienced these **symptoms before** *(please explain below)*?
Do you currently **exercise, play sports,** or **have hobbies** (*if yes, please describe below*)?

How did your **injury occur** or **symptoms begin** (*check all that apply*)?

❑ Accident - Work Related	❑ Bending	❑ Reaching	❑ Lifting
❑ Accident - Motor Vehicle	❑ Gradual Onset	❑ Falling	❑ Other
❑ Accident - Third Party / Liability	❑ No Apparent Reason	❑ Dressing	

Indicate daily **activities you are having trouble with** due to this injury or onset of symptoms (*check all that apply*)?

❑ Sitting ______ minutes	❑ Rising	❑ Lying	❑ Grooming
❑ Standing ______minutes	❑ Turning	❑ Dressing	❑ Bending
❑ Walking ______ feet	❑ Driving	❑ Reaching	❑ Athletics
❑ Sleeping ______ hours	❑ Stairs	❑ Housework	❑ Other

What **treatment & testing** have you received (*check all that apply*)?

❑ Physical Therapy	❑ Bracing	❑ Injection	❑ Medication
❑ Occupational Therapy	❑ Orthotics	❑ Myelogram	❑ Chiropractic
❑ Nerve Conduction Study	❑ CT Scan	❑ MRI	❑ X-Ray

If you had **surgery**, list the **type of surgery** ________________________ and **date of surgery** _____/_____/_____
Do you currently have any **"flu type"** symptoms (i.e. fever, coughing)? ❑ Yes ❑ No If yes, what symptoms:
Do you have any **open cuts, lesions, or wounds**? ❑ Yes ❑ No If yes, where:
Have you **fallen** in the past year? ❑ Yes ❑ No If yes, how many times: If yes to falling, did you **sustain an injury** as a result of the fall? ❑ Yes ❑ No Feeling of **unsteadiness** when standing or walking? ❑ Yes ❑ No Worries about **falling**? ❑ Yes ❑ No

Do you experience **frequent episodes** of the following (*check all that apply*)?

❑ Headaches	❑ Dizziness	❑ Nausea	❑ Ear Ringing	❑ Balance Control

Have you noticed a change in your **bowel or bladder frequency or control**? ❑ Yes ❑ No If yes, please explain:
Do you wear glasses or contacts? ❑ Yes ❑ No
Are you **currently receiving home health** services or have you **within the last 4 weeks**? ❑Yes ❑No
Have you had any physical, occupational, or speech therapy **this calendar year**? ❑Yes ❑No
Do you have a **family member** or **friend** who can assist you during your recovery and with your care? ❑Yes ❑No

Patient Name:	**DOB:**	**Account #:**

Do you have, or have you had, **any of the following** (check all that apply)?

❑	asthma	❑	cancer	❑	COPD
❑	currently pregnant	❑	diabetes	❑	epilepsy
❑	heart condition	❑	hypertension	❑	metal implants
❑	osteoarthritis	❑	osteoporosis	❑	pacemaker
❑	peripheral vascular disease	❑	previous surgery	❑	rheumatoid arthritis
❑	stroke history	❑	hearing problems	❑	problems urinating
❑	recent infection	❑	joint / muscle swelling	❑	other
List additional history:					

Use the following scales to **rate your average symptom level** (*circle the appropriate level for each body part*)
"0" = No Symptoms, "10" = Intense enough to seek emergency assistance

Back: 0 1 2 3 4 5 6 7 8 9 10	**Arm**: 0 1 2 3 4 5 6 7 8 9 10	**Leg**: 0 1 2 3 4 5 6 7 8 9 10
Neck: 0 1 2 3 4 5 6 7 8 9 10	**Hand**: 0 1 2 3 4 5 6 7 8 9 10	**Foot**: 0 1 2 3 4 5 6 7 8 9 10
Please indicate on the chart below *(reference the KEY)*, **where specifically you feel the pain** indicated above:		

KEY

///// Stabbing

xxxxx Burning

00000 Pins & Needles

_____ Numbness

Do you **take any medications** *(If **Yes**, please fill out below or you may provide a list of your medicines)*:

Prescription Medication	Dosage	Frequency	Medicine Route
			❑ Oral ❑ Injection
			❑ Oral ❑ Injection
			❑ Oral ❑ Injection

Over the Counter Medications *(Please check any OTC medications that you take regularly)*:

❑ Aspirin / Ibuprofen	❑ Antacids	❑ Cough Medicine	❑ Cold Medicine	❑ Vitamins
❑ Allergy Relief	❑ Laxatives	❑ Sleeping Aids	❑ Diet Pills	❑ Other

Do you **have allergies** to ❑ Latex ❑ Lidocaine ❑ Cortisone ❑ None Known ❑Other:

What **goals** do you have for therapy? What do you **hope to accomplish**?

My **next appointment** with my doctor is on _____/_____/_____ ❑ No appt scheduled

Patient / Legal Representative Signature:	**Date:**
Therapist Signature:	**Date:**

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PHYSICAL THERAPY

Consent & Statement of Financial Responsibility (Work Comp)

Patient Name:	**DOB:**	**Account #:**

CONSENT TO TREATMENT: I consent to rehabilitation and related services at STAR Physical Therapy, LLC. In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and / or direct contact of a sensitive nature.

CANCELLATION AND NO SHOW POLICY: We work hard to stay on schedule because your time is valuable to us! Staying on schedule also allows us to provide you with the appropriate amount of time with your therapist to maximize the benefits and give you the best possible outcomes.

As a **worker's compensation patient**, we recognize that in many cases you are not working or on limited duty. More than anything, we know how much you want and need to get back to work or full duty. We are committed to doing everything we can to help!

Some important reminders regarding your scheduled appointments...

- **Obligation to Communicate** - When you cancel or miss an appointment, it is our obligation to communicate with your employer, insurance adjuster and / or case manager regarding that appointment.
- **24 Hour Notice!** - If you have to cancel an appointment, please try to provide us with at least 24 hours notice.
- **Running Late?** - If you are running late, please call ahead and let us know. If you are running more than 15 minutes late, every attempt will be made to accommodate you. Your treatment may need to be modified or rescheduled in consideration of other patients with already scheduled appointments.
- **Frequent Cancelled or Missed Appointments** - If you regularly cancel or miss your appointments, we may ask that you return to your referring physician prior to scheduling any more therapy.

ACCESS TO AND RELEASE OF HEALTH INFORMATION: I consent to allow STAR Physical Therapy, LLC to use and disclose my protected health information (PHI) within STAR to carry out my treatment, to obtain payment and to carry out health care operation. My PHI may be disclosed to my health plan and / or its agents as necessary to verify benefits, authorize services and process medical claims. My PHI may be disclosed to outside health agencies or institutions involved in my continuing care and/or for emergency care purposes and otherwise permitted or required in the Notice of Privacy Practices.

GUARANTEE OF PAYMENT (not applicable for Worker's Compensation Claim): In consideration of services rendered to me by STAR Physical Therapy, LLC I hereby guarantee payment for any and all services not covered or allowed by insurance. I also understand that all bills are due and payable upon receipt. I understand that the patient responsibility portion of my bill will be due and payable at the time of service. I understand that should my account with STAR become delinquent and turned over to a collection agency, that I, the undersigned, will be responsible to pay all collection agency fees, court costs or any other fees / costs associated with resolving my account balance.

RETURNED CHECKS: We are happy to accept your personal check; however, if your check is returned for any reason, you expressly authorize your account to be electronically debited or bank drafted for the amount of the check plus any applicable fees. The use of a check for payment is your acknowledgement and acceptance of this policy and its terms and conditions.

ASSIGNMENT OF BENEFITS: I hereby assign STAR Physical Therapy, LLC all my rights and claims for reimbursement under my health insurance policy. I agree to cooperate with STAR and to provide such information as is needed to establish my eligibility for such benefits.

WAIVER AND RELEASE: I hereby release, discharge and acquit STAR Physical Therapy, LLC its agents, representatives, affiliates, employees or assigns of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.

NOTICE OF PRIVACY PRACTICES: I acknowledge that a copy of the Notice of Private Practices is posted in the clinic and available for my review. Furthermore, I understand that I can request, and immediately receive, a copy of this document.

Patient / Legal Representative Signature:	**Date:**

FORM C-31

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELPOMENT
Division of Worker's Compensation

MEDICAL WAIVER AND CONSENT

It is a crime to knowingly provide false, incomplete or misleading information to any party to a worker's compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.

THIS MEDICAL AUTHORIZATION FORM ONLY PERMITS THE EMPLOYER OR THE DIVISION WORKER'S COMPENSATION TO OBTAIN MEDICAL INFORMATION THROUGH ORAL OR WRITTEN COMMUNICATION, INCLUDING, BUT NOT LIMITED TO, CHARTS, FILES, RECORDS, AND REPORTS IN THE POSSESSION OF A MEDICAL PROVIDER AUTHORIZED BY THE EMPLOYER PURSUANT TO T.C.A § 50-6-204 AND A MEDICAL PROVIDER THAT IS REIMBURSED BY THE EMPLOYER FOR THE EMPLOYEE'S TREATMENT.

I, ____________________, having filed a claim for worker's compensation benefits, do hereby waive any physician-patient, psychiatrist-patient, or chiropractor-patient privilege I may have and hereby authorize

STAR Physical Therapy
(Name of Medical Provider)

to furnish to the employer (or the employer's representative, such as the insurance company) and/or the Division of Worker's Compensation any information reasonably related to my work-related injury. The authorization includes, but is not restricted to, a right to review and obtain copies of all records, x-rays, x-ray reports, medical charts, prescriptions, diagnoses, opinions and courses of treatment.

This authorization shall remain valid for 180 days following its execution. A photocopy of the authorization may be accepted in lieu of the original.

Dated: _____________________, 20____

___________________________ ____________________
Patient Last 4 numbers of SSN

____
Witness

Pursuant to the Rules of the Department of Labor and Workforce Development 0800-2-17.15, any physician, psychiatrist, chiropractor, podiatrist, hospital or health care provider shall, within a reasonable time, not to exceed thirty (30) days, provide the requesting party with any information or written material reasonably related to the injury for which the employee claims compensation.