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:	**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)

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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:		

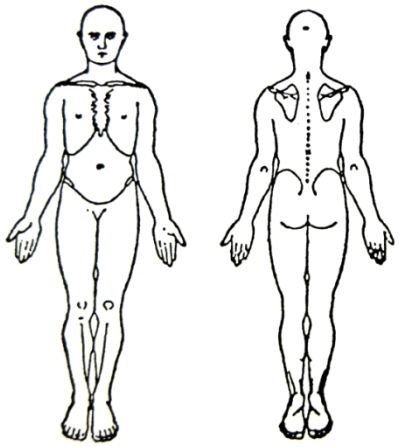
KEY

/ / / / / 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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Consent & Statement of Financial Responsibility

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.

Some important reminders regarding your scheduled appointments...

- **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: 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:

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Healthcare Provider's Lien

Patient Name: Patient ID:

This is an Agreement and Acknowledgement of Financial Responsibility and is executed on behalf of _____.

WHEREAS, Patient has been prescribed physical / occupational therapy for injuries sustained as a result of an injury or accident;

WHEREAS, Patient is pursuing reimbursement for services from a third-party or through litigation to recover damages for such injury or accident (the "Claim");

WHEREAS, FACILITY ("STAR") is willing as a courtesy to Patient, to delay collection of its fee for up to twenty-four (24) therapy visits ***Initial x*** _____ rendered in order to allow Patient time to recover monetary compensation from a third-party or through litigation to cover the cost of the therapy services.

NOW, THEREFORE, IT IS ACKNOWLEDGED AND AGREED THAT:

STAR agrees to refrain from attempting to collect its fees for services rendered to the Patient which are the subject of the Claim for the period set forth herein, subject to compliance by patient with Patient's agreements and obligation as set forth herein.

Patient acknowledges and agrees that it is their sole obligation to pay for therapy services rendered for injuries arising from the accident. ***Initial x*** _____ Patient grants a lien on and / or assigns any settlement or judgment in which Patient receives from the Claim in an amount equal to the lesser of the charges for the therapy services rendered, or the maximum amount permitted by law. Patient futher agrees to execute such further documents as necessary for STAR to preserve its right to enforce said lien and / or assignment. STAR will not recognize any restrictive endorsements and will treat a restricted check as a regular payment on the patient's account and not as payment in full for services rendered.

Patient understand and agrees that payment of this obligation in full is not contingent on any settlement judgment or verdict by which Patient may eventually recover fees but in any case is due in full within 365 days. ***Initial x*** _____ Patient acknowledges and agrees that in the event Patient does not pay or make satisfactory arrangements to pay for the therapy services, the account may be transferred to an outside collection agency. Patient agrees to be responsible for any expenses incurred in collecting Patient's account, including all fees, court costs, reasonable attorney's fee and all other collection related expensed.

By signing below Patient or Guarantor acknowledges that he/she has read, understands and hereby accepts the above obligations and agreements.

Patient / Guarantor Signature: ***x*** _____ **Date:** _____

STAR Employee Signature: ***x*** _____ **Date:** _____

Legal Counsel (if applicable)

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms of the above and agree to withhold such sums from any settlement judgment or verdict as may be necessary to protest STAR Physical Therapy, LP.

Attorney Signature: ***x*** _____ **Date:** _____

Print Name: ***x*** _____

TELEHEALTH SERVICES CONSENT FORM

1. I voluntarily wish to engage in a telehealth visit with my physical therapy provider at STAR Physical Therapy, Limited Partnership (hereinafter "PT Provider").

2. My PT Provider has explained to me that HIPAA-compliant video-conferencing technology will be used to enable the telehealth visit. I understand this visit will not be the same as an in-person, direct patient-physical therapy provider visit due to the fact that I will not be in the same room as my PT Provider.

3. I understand there are potential risks associated with using video-conferencing technology, including (a) the risk of technical interruptions or failures, or (b) the risk of unauthorized access to my healthcare information. I understand that either my PT Provider or I may discontinue the telehealth visit if it is felt that the video-conferencing connections are not adequate or secure for the telehealth visit.

4. I hereby hold harmless and agree not to sue PT Provider, and its parent company, subsidiaries, agents, affiliates, associates, officers, directors, owners, and employees (collectively "Releasees") from any losses or damages due to loss of, or unauthorized access to, my health information caused by or alleged to be caused by technical interruptions, failures, or difficulties in connection with the telehealth services provided by Releasees, to the fullest extent permitted by law.

5. I understand that PT Provider may share my health information with other individuals for scheduling and billing purposes. I further understand that other staff members may be present during my telehealth visit to operate the video-conferencing equipment, as needed, and the above-mentioned individuals will maintain confidentiality of the information obtained.

6. I understand that for each telehealth session, I will be asked to show a photo ID to confirm my identity. Likewise, I have the right to ask PT Provider practitioner to show his/her identification and credentials to confirm his/her identity.

7. By signing this form, I certify that:
   - I have read or had this form read and/or had this form explained to me.
   - I fully understand its contents including the risks and benefits of engaging in the telehealth session.
   - I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.
   - I understand my email address will be used for telehealth purposes.

_____	_____	_____
Patient Printed Name	**Email Address**	**Date of Birth**
_____	_____	
Patient or Parent/Legal Guardian Signature	**Date**	