Patient Express Registration

www.ratnerpt.com

Date: ______________________

Please Fill-Out Entire Form Completely and Legibly

Patient Info:

Full Name______________________________ Date of Birth: __________ Age:_____ Sex: Male Female

Address: ______________________________ City/State/Zip:______________________

Email Address:______________________________ Cell Phone:______________________

Occupation: ________________ Work Status: ☐ Currently Employed ☐ Retired ☐ Disabled ☐ Student

Emergency Contact Person & Phone:______________________________

Primary Physician:__________________City/State:______________ Phone #:______________

If patient is a MINOR, parent/guardian's name and relation: ______________________________

My Condition Info **ALL INFO REQUIRED**

My injury/aliment is related to...

☐ NO INJURY: What do you think may have caused it?

☐ SURGERY: ______________________________

☐ WORK INJURY:______________________________

Payment Info (check only one box)

I am paying TODAY by...

☐ INSURANCE:

_____ I will assign my benefits to you by completing the "Assignment of Benefits" Form.

My coinsurance/copay is $______________

My deductible is $__________________

☐ CASH, CHECK, CREDIT and would like a...

_____ 30% discount by **not** filing insurance

_____ Payment plan. Fees may apply.

Referral Info How did you hear about us?

☐ Friend/Family ________________ ☐ Internet ☐ Facebook ☐ Insurance ☐ Instagram ☐ Other: ____________

☐ Physician/Dentist/Chiropractor/Nurse: Give Details: ______________________________

Important Rule & Policies

1. Late Policy: If I'm late more than 10-minutes to my scheduled appointment, I may be rescheduled or asked to wait for next available open time slot.
2. 48-Hour advance notice is required for changes to my appointment and failure to give said advance notice may result in a $50 cancellation fee being added to my account NO SHOWS ARE BAD! Not showing for an appointment without notice will result in a $50 fee added to my account.
3. All co-pays and/or deductibles are due and owing at time of service.
4. Cell phones must be shut OFF or silent.
5. Children requiring supervision are NOT allowed to attend sessions with you without prior authorization from provider.
6. If you are experiencing any financial hardship, please notify us immediately so we can create a payment program that is feasible.
7. If for any reason you are NOT satisfied with the care received, please immediately call our administrator at (817) 259-1255.

Patient Signature (or Guardian) ______________________________Date:____________

PRE-EXAM FORM

In order to evaluate your condition fully, please be as accurate as possible. Thank you.

Patient Name:______________________________ Age:_____ Gender: ❑ Female ❑ Male

Occupation:______________________________ Are you working now? ❑ Yes ❑ No

Current Job status/duties: ❑ Normal ❑ Modified duty ❑ Off work ❑ Unemployed

STRESS Level : low 1----2----3----4----5 high What's the main cause? ______________________

Pain level 0-10 (0 = none, 10 = call 911): _______ Location of pain on body: ______________________

Hand Dominance: ❑ Right ❑ Left Smoker: ❑ Yes ❑ No

Where did this happen?

____

Date of injury/surgery? ____

What happened?

____

Pain relieved/better with: ______________________ Pain worse with: ______________________

Have you received physical, occupational, speech, chiropractic therapy or home health services in the past year? ❑ Yes ❑ No

If for this injury, what was the result?

____

Are you currently receiving any Home Health services? ❑ Yes ❑ No

List ONE ACTIVITY you are unable to do, that you absolutely want to be able to do again:

____

____

Have you ever had this same (or similar) pain/problem before?

❑ Yes (when and describe) ______________________________________ ❑ No

How optimistic are you that you'll get better?

❑ Not at all ❑ Mildly optimistic ❑ Fairly ❑ Very optimistic ❑ Extremely

What are some potential obstacles to you getting better?

____

____

Over the next 30-days, how many hours per week will you commit to getting better?

____

What are you expecting from therapy?

____

PRE-EXAM FORM

Medical History – Please indicate if you have had any of the following, what type and dates if applicable:

Heart Problems	Y	N		High Blood Pressure	Y	N	
Diabetes	Y	N		Allergies	Y	N	____________
Lung Problems	Y	N		Back/Neck Problems	Y	N	
Asthma	Y	N		Shortness of Breath	Y	N	
Dizziness	Y	N		Chest Pain	Y	N	
Stroke	Y	N	____________	Traumatic Head Injury	Y	N	
Blood in Urine	Y	N		Hernia	Y	N	____________
Cancer	Y	N	____________	Arthritis	Y	N	
Seizures	Y	N		Osteoporosis	Y	N	
Pace Maker	Y	N	____________	Implanted devices	Y	N	____________

List all medical conditions you have (or were told you have):

____

____

Current Medications:

____

____

____

____

Past medical/surgical history (including date, if applicable):

____

____

____

____

I understand that my candidacy for a rehabilitation program will be dependent upon my ability and willingness to improve. I have answered the questions above honestly and accurately to the best of my ability. The doctor/therapist will determine whether or not I am a viable candidate for a rehabilitation program and that my approval into their program is not guaranteed.

Patient Signature :______________________________Date:____________

Financial Policy and Assignment of Benefits to Ratner Center for Physical Therapy and Wellness, LLC

Patient Name:______________________________ DOB ______________

Insurance Member/ID #:__________________________ Group #________________

Insured Name:__________________________ Insured DOB ______________

Your relationship to the Insured: ☐ Self ☐ Parent ☐ Spouse ☐ Other:____________

I hereby instruct and direct my health insurance carrier ______________________ insurance company to pay by check made out and mailed to:

Ratner Center for Physical Therapy and Wellness, LLC
5500 Overton Ridge Blvd, Suite 228 Fort Worth, TX 76132
(817) 259-1255

If my/this current policy prohibits direct payment to my healthcare providers, then I hereby also instruct and direct you to make out the check to me and **mail it to the above address** for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance due and owing for all of said professional service charges over and above this insurance payment.

(Check each box and sign at the bottom)

- ☐ A photocopy of this Assignment shall be considered as effective and valid as the original.
- ☐ I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- ☐ I authorize the use of this signature on all insurance submissions.
- ☐ I authorize Ratner Center for Physical Therapy and Wellness, LLC to deposit all checks made in my name.
- ☐ I authorize Ratner Center for Physical Therapy and Wellness, LLC to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- ☐ **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE AND LIABLE FOR ALL CHARGES, WHETHER OR NOT PAID BY INSURANCE, WHICH WERE RENDERED TO ME AND I ACKNOWLEDGE THAT MY FAILURE TO FULLY PAY MY ACCOUNT WILL RESULT IN THIS MATTER BEING TURNED OVER TO OUR ATTORNEYS AND/OR A COLLECTION AGENCY FOR COLLECTION.**

Dated this ______ day of ____________________, 20_____.

______________________________ ______________________________
Signature of Policyholder Witness

____
Signature of Claimant, if other than Policyholder

5500 Overton Ridge Blvd., Ste 228
Fort Worth, TX 76132
P: (817) 259-1255
F: (817) 764-9008

Patient Notification Policy and Consent

Patient's Name:________________________________ DOB:______________

In order to insure that patients receive time-sensitive information and/or other informational healthcare messages, Ratner Center for Physical Therapy and Wellness, LLC (Provider) will send notifications to patients who want to receive such notifications. If you sign this notification and consent and want to receive such notifications from Provider, there will not be a separate charge for these notifications; however, depending on the terms and conditions of your wireless carrier contract/plan, fees and/or restrictions may be imposed upon you for receiving such notifications. Please contact your wireless carrier about such fees and/or restrictions prior to providing your consent herein to such notifications from Provider.

It is important for you to note that certain communications, including, without limitation to, email and text message, which contain your protected health information ("PHI"), are not invariably secure, since certain communications can be intercepted, delivered and/or addressed to an unintended recipient, and/or improperly accessed while in storage and/or during transmission.

In compliance with the Health Insurance Portability and Accountability Act ("HIPAA"), Provider is required to maintain the privacy and security of your PHI. In addition, pursuant to the HIPAA Privacy Rule and Provider's Notice of Privacy Practices, provider will not use and/or disclose your PHI without your written authorization, except as may be permitted by law for the purposes of payment, treatment and health care operations. Furthermore, when Provider is authorized and/or permitted to use and/or disclose your PHI, Provider will try to limit the use and/or disclosure of your PHI to the minimum amount necessary to accomplish the intended purpose of the use and/or disclosure of your PHI. If you choose to have Provider disclose your PHI to a third party, you must properly complete Provider's HIPAA Authorization Form, which is available from Provider upon request.

You may revoke this consent by providing written notice of revocation to the Provider. The revocation will become effective on the day the Provider receives the written revocation of the consent, and any other prior notification from Provider will not be affected.

I, the undersigned, hereby consent to receive notifications from Provider, which notifications may include my PHI, by the following methods of communication as indicated below, with the full understanding of all risks involved with such notifications from Provider, and I agree to assume all responsibility for informing Provider in writing of any changes to any of the methods of communications that I indicated below and for insuring that the methods of communication that I indicated below are secure, with password protection used where applicable, and I further agree that Provider shall not be liable in any manner for any unauthorized disclosures of my PHI to a third party through any of the methods of communication I authorized below nor for any fees and/or restrictions that may be imposed upon me for receiving notifications from Provider:

☐ Mobile Device*: (______)____

☐ Text Message*: (______)____

☐ E-Mail: ____

☐ Opt-out of receiving text message and email communications from Provider

*wireless carrier's standard message rates, data rates, and/or restrictions may apply, and by consenting to receive notifications from Provider you agree to be solely responsible for all fees that you may incur from receiving notifications from Provider.

____ ____________________
Patient (Guardian) Name Date

____
Patient (Guardian) Signature

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Informed Consent for Physical Therapy Services and Release of Claims

The purpose of physical therapy is to treat disease, injury and/or physical disability by examination, evaluation, diagnosis, prognosis, and intervention with the use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving maximum potential within their capabilities and to accelerate convalescence and reduce the time of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

Response to physical therapy intervention varies from person to person and therefore, it is not possible to accurately predict your response to any specific modality, procedure, or exercise protocol. Ratner Center for Physical Therapy and Wellness, LLC (Provider) does not guarantee what your reaction will be to a specific treatment, nor that the treatment will resolve the condition that you are seeking treatment for. Furthermore, there is the possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury. It is therefore very important for you to communicate with your treating physical therapist of all health problems, medical conditions, allergies, drugs and medications you are taking.

You may decline any part of your treatment at any time, should you feel any discomfort or pain or have other unresolved concerns. You may ask your physical therapist about your planned treatment based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, you may also discuss the potential risks and benefits involved in your treatment.

I acknowledge that I have read this Informed consent and release form and fully understand all of its content and all risks involved in physical therapy and the use of all equipment by Provider. I understand that my use of any equipment may result in injury (strains, fractures, etc.) to me. I agree to fully cooperate, participate in all physical therapy procedures, and comply, to the best of my ability, with the established plan of care. I hereby authorize the release of all of my medical records and information to appropriate third parties. I furthermore assume all risks and responsibilities for any damages and/or losses that I may incur and I hereby fully and forever release, waive, discharge, hold harmless, defend and indemnify Provider and it's representatives, employees and assigns from any and all claims, actions, bodily injury, property damage, loss of services or otherwise which may arise from my use of provider's equipment, and/or participation in receiving services of Provider, both presently and in the future.

______________________________ ______________
Patient (Guardian) Name Date

____
Patient (Guardian) Signature