LIVACTIVE THERAPY CENTER

# Patient Registration Form

First Name _____ MI _____ Last Name _____

Date of Birth _____ Age _____ Weight _____ Height_____

Address _____ Apt_____City_____State _____ Zip _____

Home # _____ Cell# _____ Alt # _____

Email _____

☐Single ☐Married ☐Divorced ☐Employed ☐Retired ☐Student

**Emergency Contact:**

**May this person be informed of any relevant medical conditions?** ☐Yes ☐No

Name_____ Phone _____Relation to Patient _____

**Physician Information**

Primary Care Physician_____ Phone # _____

**I began having pain/symptoms on or about**: _____/_____/_____

**Surgery for your condition:** ☐ No ☐ Yes Date _____/_____/____

Explain Surgical Procedure: _____

**I am currently taking the following medications (check all that apply)**:

☐Pain pills ☐ Anti-inflammatory ☐ Muscle relaxants ☐ Antidepressants ☐Blood thinners

Please list medication(s) or attach a list: _____

**I have (or have had) (check all that apply):**

| | | |
|---|---|---|
| ☐ cancer | ☐depression /anxiety | ☐thyroid problems |
| ☐ arthritis | ☐rheumatoid arthritis | ☐osteoporosis |
| ☐ anemia | ☐seizures | ☐blood clots |
| ☐ heart disease / condition | ☐lung problems | ☐drug or alcohol |
| ☐ chest pain / angina | ☐plastic or metal implants | ☐stroke |
| ☐ asthma | ☐liver problems | ☐pacemaker |
| ☐ circulation problems | ☐ulcers | ☐fibromyalgia |
| ☐ bladder / kidney problems | ☐ Other _____ | |

☐ high blood pressure (If yes, is this well controlled) ☐yes ☐ no ☐unsure

☐diabetes (If yes, is this well controlled) ☐ yes ☐ no ☐unsure

***Current*** smoker ☐ yes ☐ no ***Past*** smoker ☐ yes ☐ no

***Currently*** pregnant ☐ yes ☐no

**I have the following allergies:** _____

**I would rate my pain *AT WORST* as**:

0 (None) 1 2 (Annoying) 3 4 (Uncomfortable) 5 6 7 (Horrible) 8 9 10 (Excruciating)

**I would rate my pain *AT BEST* as**:

0 (None) 1 2 (Annoying) 3 4 (Uncomfortable) 5 6 7 (Horrible) 8 9 10 (Excruciating)

## Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Liv Active Therapy Center for the purposes of evaluating or providing treatment to me, obtaining payment for my health care bill or conducting health care operations of Liv Active Therapy Center. I understand that evaluation or treatment of me by Liv Active Therapy Center may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Liv Active Therapy Center. is not required to agree to the restrictions that I may request. However, if Liv Active Therapy Center agrees to a restriction that I request, the restriction is binding on Liv Active Therapy Center. I have the right to revoke this consent, in writing, at any time, except to the extent that Liv Active Therapy Center. has acted in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my therapist, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Liv Active Therapy Center. HIPAA Notice of Privacy Practices prior to signing this document. The Liv Active Therapy Center. HIPAA Notice of Privacy Practices has been provided to me. The HIPAA Notice of Privacy Policies describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Liv Active Therapy Center. The HIPAA Notice of Privacy Practices for Liv Active Therapy Center. is also available at the front desk and on the Liv Active Therapy Center. website at www.LivActiveTherapy.com . This HIPAA Notice of Privacy Policies also describes my rights and Liv Active Therapy Center. duties with respect to my protected health information. Liv Active Therapy Center. reserves the right to alter the Liv Active Therapy Center. HIPAA Notice of Privacy Practices to reflect any changes to the federal HIPPA policies. I may obtain a revised notice of privacy practices by accessing the Liv Active Therapy Center website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

## Release of Information and Authorization for Detailed Messages

The undersigned authorizes Liv Active Therapy Center whether signing as patient or guardian, to release medical information as requested by insurance companies, employers, and other responsible parties, unless otherwise directed. If authorization to release information is denied, payment for services rendered will be due at the time of services. I give consent to Liv Active Therapy Center. to leave detailed information with an individual or on an answering machine regarding treatment, appointment confirmation, billing information, or other related information. Unless notified in writing, this consent will remain in effect permanently.

## Cancellation/No Show Policy

All patients who no show for their appointment will be charged a $25.00 No Show fee. Please call before your appointment to cancel if you are not going to be able to attend your session. All missed appointments are documented in your chart. If no effort has been made to reschedule, Liv Active Therapy Center. will attempt to contact patient. After the third failed attempt to schedule patient, the therapist will contact the referring physician and advise discharge from physical therapy due to non-compliance by the patient. This policy helps insure the treatment necessary for fast recovery and we appreciate your cooperation with this policy.

## Assignment of Insurance Benefits

The undersigned agrees, whether signing as patient or guardian, direct payment to Liv Active Therapy Center of any insurance benefits and it is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment. I have been informed of my benefits and understand that any co-pay or share or cost will be charged, and I am responsible for payment of any such charge that may be due. All co-pays are due at the time of service. I also authorize Liv Active Therapy Center to deposit checks received on my account when made out to me.

## Patient/Guardian Authorization for Treatment

I hereby grant my consent for therapy evaluation and treatments rendered by Liv Active Therapy Center. Also, my initials indicate that I have read and acknowledge the above topics, respectively.

**Patient Name (Print)** _____

**Patient/Guardian Name:** _____

**Patient/Guardian Signature:**_____ **Date:** _____