Be Fit!
Physical Therapy & Pilates

PATIENT REGISTRATION FORM

NAME _____ BIRTHDATE _____

E-MAIL ADDRESS _____ OCCUPATION _____

Marital Status: ☐ Married ☐ Single ☐ Widow/Widower ☐ Divorced

Is your condition a result of (Please Check One):
☐ Work Related ☐ Injury ☐ Auto Accident

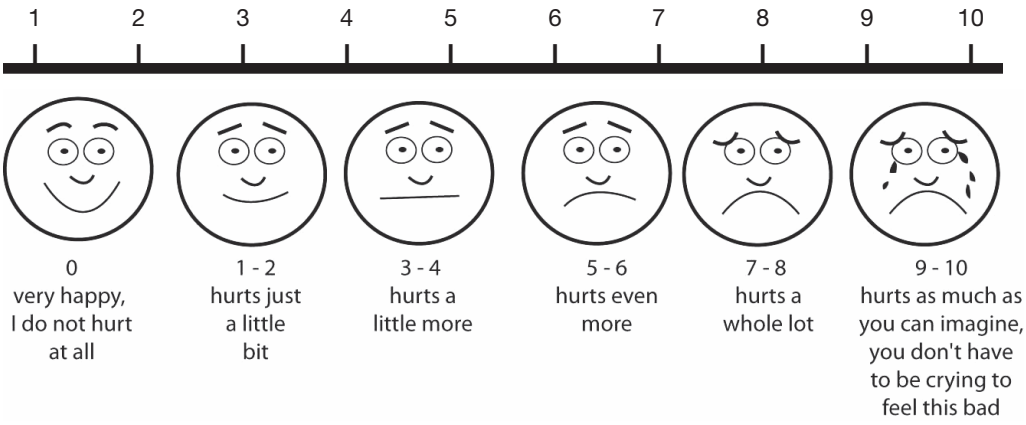
WHAT IS THE NATURE OF YOUR INJURY _____

When was the date of Injury/Accident/Other: _____

☐ Yes ☐ No Do you have any pain?

If yes, please mark the areas on the drawings below.

On the following scale of 0 – 10, how would you rate your pain?



Pain is: ☐ Constant ☐ Intermittent

630.964.4008 | F 630.964.4117 | **BeFitPT.com**
4934 MAIN STREET, DOWNERS GROVE, IL 60515

Do you have other symptoms?

☐ Swelling ☐ Stiffness ☐ Weakness ☐ Tenderness ☐ Tightness
☐ Limited Motion ☐ Numbness ☐ Tingling Sensation

☐ Others _____

Due to your condition do you have difficulty:

☐ walking
☐ balancing
☐ sleeping
☐ getting up from bed/chair
☐ performing work duties
☐ performing light domestic duties
☐ performing heavy domestic duties
☐ performing your recreation/ sport activities
☐ personal care activities (dressing, washing, etc.)
☐ commuting/ traveling

_____
LEISURE ACTIVITIES OR HOBBIES

_____
WHAT ARE YOUR GOALS?

_____
HOW DID YOU HEAR ABOUT BE FIT PHYSICAL THERAPY?

Please list any PRESCRIPTION medication you are currently taking: (pills, injections, and/or skin patches)

_____

_____

Please check the following OVER-THE-Counter medication you have taken in the last week.

☐ Advil ☐ Motrin ☐ Ibuprofen
☐ Tylenol ☐ Decongestants ☐ Vitamin
☐ Antacids ☐ Laxatives ☐ Antihistamines
☐ Others _____

Please check any of the following medical professional you are currently seeing:

☐ Medical Doctor ☐ Osteopath ☐ Physician Assistant ☐ Physical Therapist
☐ Chiropractor ☐ Dentist ☐ Nurse Practioner

_____ _____
REFERRING PHYSICIAN OTHER PHYSICIANS

If you have been seen by any of the above during the last three months, pleas describe for what reason (illness, medical condition, physical examination, ect.)

_____

_____

Please check any of the following condition that you have EVER been diagnosed with and Describe below

☐ High/Low blood pressure	☐ Heart Problems	☐ Thyroid problems
☐ Diabetes	☐ Emphysema	☐ Asthma
☐ Chemical Dependency	☐ Alcoholism	☐ Multiple sclerosis
☐ Hepatitis	☐ Depression	☐ Stroke
☐ Rheumatoid arthritis	☐ Tuberculosis	☐ Kidney disease
☐ Anemia	☐ Epilepsy	☐ AIDS
☐ Other Arthritic Conditions	☐ Cancer	☐ Other

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

Please describe any injures for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

Have you currently experienced:

☐ Yes	☐ No	Weight loss/ Gain
☐ Yes	☐ No	Nausea/ Vomiting
☐ Yes	☐ No	Fatigue
☐ Yes	☐ No	Weakness
☐ Yes	☐ No	Fever/ Chills/ Sweats
☐ Yes	☐ No	Numbness or Tingling
☐ Yes	☐ No	Do you have any pain?

Is there anything else you would like for us to know?

CONSENT FOR TREATMENT & RELEASE OF INFORMATION

Insurance Authorization and Assignment of Benefits

I Authorize Be Fit Physical Therapy & Pilates, LTD to deposit checks received on my account when made out to me. I understand if the insurance company sends payment directly to me, I am responsible for returning payment over to Be Fit Physical Therapy & Pilates, LTD upon receipt of the check. Failure to do so will result in me being responsible for the total balance due on the account in full. I understand that I AM RESPONSIBLE for any and all charges, costs, and fees incurred during my evaluation and treatment program at Be Fit Physical Therapy & Pilates, LTD., not covered by my insurance carrier (S). In the case of no insurance coverage, I am responsible for payment in full. If I am unable to pay the balance until paid in full, It is my responsibility to make financial arrangements and make regular payments on my account balance until paid in full. Further, I understand that all delinquent accounts are turned over for collection to a third party agency if no payment is received for 75 days. This agency does report to all credit bureaus for recording on personal credit history. If I fail to pay for these services, I agree to pay the collection agency fees, attorney fees, and court costs incurred in collecting the dept. I consent to the above billing procedures as confirmed by my signature below.

I, or my (child) has a condition, which a licensed physician has prescribed physical therapy as part of my treatment plan. I request and consent to Be Fit Physical Therapy & Pilates, LTD and its physical therapist, assistants, and professional staff, to perform therapeutic procedures that my be necessary for my rehabilitative treatment as necessary and desirable in the exercise of professional judgment. It is not possible to make guarantees concerning the results of this or any treatment. I acknowledge that no such guarantees have been made to me. I also authorize Be Fit Physical Therapy & Pilates, LTD to obtain and release any medical information, verbal or written, necessary to provide appropriate patient care. I understand that all information exchanged is maintained under the Be Fit Physical Therapy & Pilates, LTD confidentially policy.

Cancellation/No Show Policy

We understand that there are times when you must miss an appointment due to an emergency. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment.

If your appointment is not cancelled at least 24 hours in advance, you will be charged a $25.00 fee; this will not be covered by your insurance company. Patient Initials: _____

PATIENT SIGNATURE DATE

WITNESS SIGNATURE DATE

RELEASE OF PROTECTED HEALTH CARE INFORMATION VIA TELEPHONE TO ANSWERING MACHINE OR VOICE MAIL.

I give my consent and authorization for the Medical or Billing Staff of Be Fit Physical Therapy & Pilates, LTD., to leave protected health care information about me or for me on any answering machine or voice mail via the telephone at the number I have listed below. I understand I revoke this privilege at any time by submitting my request in writing to retrieve results of all test and procedures.

SIGNATURE PHONE NUMBER DATE

RESTRICTIONS (S)

Pursuant to Health insurance portability and Accountability Act of 1996, I acknowledge that I have received a copy of the Notice of Privacy Practice. Initial: ____ Date: _____