

**Amber Hill Therapy Centers
Registration Form**

Patient Name _____ Date of Birth _____

Social Security Number _____ Address _____

Phone Number (____) _____

Referring Physician _____ Doctor's Phone (____) _____

Primary Care Physician _____ PCP Phone (____) _____

Email _____ (You will automatically be enrolled to receive updates, notices and alerts including closures and our monthly newsletter) You may opt out by initialing here _____. Once enrolled, you may opt-out at any time.

Is this problem related to a motor vehicle accident or work-related injury? No Yes

If you answered yes to the above, please complete the following insurance information:

PIP or Worker's Compensation Carrier _____ Phone (____) _____

Adjustor's Name _____ Claim Number _____

Claims Address _____ City, State, Zip _____

Have you had prior therapy this year? No Yes If yes, for what condition? _____

Guarantor Information (Please complete if patient is under 18.)

Guarantor Name _____ Guarantor Phone (____) _____

Address _____

Guarantor's SSN _____

How did you hear about us? Please circle one

Doctor referral Friend/Family Google Grocery Carts Ad in paper/Magazine

Website Internet search self-referral Event _____ Other _____

Patient Name: _____ Date of Birth: _____

Please complete the following section regarding your current condition.

1. Please briefly describe your current injury/surgery and how the current episode began.

Onset date of current condition: _____ Have you had surgery for the current injury? Yes No
Surgery Date: _____

2. Please list all physicians and healthcare providers you are seeing for this condition.

3. History of Pain: Please circle the number corresponding with your level of pain.

Current pain level

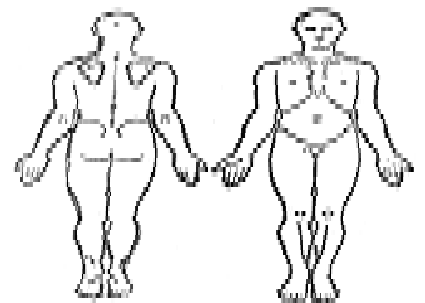
(Best) 0 1 2 3 4 5 6 7 8 9 10 (Worst)

Worst pain level in the last week

(Best) 0 1 2 3 4 5 6 7 8 9 10 (Worst)

Best pain level in the last week

(Best) 0 1 2 3 4 5 6 7 8 9 10 (Worst)



4. Description of Pain: Please mark the location of your pain on the drawing and describe by circling all of the following that apply:

Burning, Shooting, Achy, Sharp, Stabbing, Constant, Intermittent, Throbbing

5. Have you been previously treated for this condition? If so, please describe previous treatment and date(s).

6. What is your occupation? _____

Are you working at light or full duty? _____

If you are not working due to injury, when was the last date you worked? _____

7. If you are having difficulty or unable to perform any of the following activities, circle item?

- | | | | |
|--------------------|-------------------|----------|-------------------|
| Sitting | Managing Children | Driving | Carrying |
| Sleeping | Walking | Shopping | Dressing |
| Standing | Preparing Food | Reaching | Walking Distances |
| Flight of Stairs | Rolling in bed | Lifting | Bathing |
| Stand from sitting | Squatting Down | Stooping | Grooming |

Other: _____

8. Have you fallen in the past 12months? Yes No

If yes, how many times have you fallen in the past 12months? _____

If you have fallen, have any of your falls resulted in injury? Yes No

If your falls resulted in injury, please describe.

Patient Name: _____ Date of Birth: _____

Amber Hill Therapy Centers Important Patient Disclosures

Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for *Amber Hill Physical Therapy* to furnish medical care and treatment to _____ considered necessary and proper in diagnosing or treating his/her physical condition.

(Patient name)

If patient is under 18 years of age I give Amber Hill Physical Therapy permission to treat _____ if unattended in the treating area without an adult present. (Patient Name)

Benefit Assignment/Release of Information

I hereby assign all medical benefits to which I am entitled, including private insurance and any other health plans, to *Amber Hill Physical Therapy*. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

Scheduling and Cancellation Policy

Amber Hill Physical Therapy reserves the right to bill a minimum \$40 no show fee for any appointment not canceled 24 hours in advance. Consistency in treatment is important to your rehabilitation outcome therefore multiple cancellations may result in termination of your treatment or a loss of prime (desired) schedule time.

If you are late for an appointment we may not be able to provide you with treatment as a courtesy to our other patients.

Financial Policy Statement

It is our policy to bill your insurance carrier as a courtesy to you, although you are responsible for the entire bill when the services are rendered. A payment of your estimated share is required to be paid upon each visit. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. If your carrier pays any funds in excess you will be refunded the credit. All patient balances over 60 days from date of transfer to patient responsibility, will be charged interest monthly at the rate of 10% annually. We reserve the right to discontinue treatment if no attempt to resolve large past due balances is made.

Patient Responsibility

While being treated at Amber Hill Physical Therapy, there may be the need to use certain products to improve your treatment. **As the patient, you are responsible for providing these items at home use. (Exp. Theraband, Electrical Stimulation Pads, Hand therapy products such as Coban, Stretch bandages, TubiGrip, Stockinette or supplies used for Splints)** You may provide these items yourself or you may purchase them from AHPT at a reduced price. These items are not considered durable medical equipment and the cost may not be covered by your insurance company. You are responsible for the cost of any items purchased. AHPT will provide you with a receipt to submit to any Health Care Savings or Flex plans.

Patient Agreement

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by *Amber Hill Physical Therapy*, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

Patient or Responsible Party _____ **Date** ___/___/___

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received the Notice of Privacy Practices from Amber Hill Physical Therapy Inc. The notice is dated April 14, 2019.

Signature: _____ **Date:** _____

In lieu of patient signature, I, _____, a staff member of Amber Hill Physical Therapy Inc, state that _____ has been given our current Notice of Privacy Practices.