PATIENT REGISTRATION FORM

Today's Date:		
Patient: Last Name	First Name	
Home Phone Number:	Cell Number:	***Email:***
Street Address		
City	State	Zip Code
DOB	Age	
Marital status (circle one) Single Married Divorced Sep Widowed		Occupation:
Referring Physician:		Phone Number:
Primary Care Physician:		Phone Number:
Emergency Contact Name:		Relationship:
Emergency Contact Numbers: Home/Cell		Work

INSURANCE INFORMATION

Insurance Company Name:		
Group #:	Policy #	Member ID#
Name on Policy:	Relationship to Patient:	DOB:
Secondary Insurance Company Name:		
Group #:	Policy #	Member ID#
Name on Policy:	Relationship to Patient:	DOB:
Name of Responsible Party: (if different than patient)	Last name	First Name
Date of Birth:	Address:	
Home Phone:	Cell Phone:	Work Phone:

GENERAL MEDICAL HISTORY- *NON PELVIC FLOOR*

Date: _____

Name: _____
Last First

Birth Date: _____ Birth Place: _____ Gender: □ Male □ Female

Allergies: _____

Current Medications/ Drug Supplements (Any vitamins or over the counter drugs taken on a regular basis :

_____

_____

Current/Chronic Medical Conditions/Surgeries & Any Pertinent Family History:

_____

_____

What brings you to our office today?

_____

Do you have any special beliefs that would be important for us to know in regards to your medical care? _____

_____

Tobacco Use: □ None □ Current User

□ Prior Use: Year Started _____Year Quit _____ Amount _____

Alcohol Use: ☐ None ☐ Occasional use ☐ Weekly ☐ Daily Total # per week: _____

Drug Use: ☐ None ☐ Yes If yes, Type: _____ How often: _____

Consent to Treatment: I hereby consent to receive care for therapy services by Rosipal Institute for Pelvic Therapy Solutions. I consent to medical treatment as is deemed necessary or advisable by the physical therapist.

Patient Signature: _____ Date: _____

OSWESTRY LOW BACK DISABILITY QUESTIONNAIRE

Instructions: this questionnaire has been designed to give us information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you at this time. We realize you may consider 2 of the statements in any section may relate to you, but please mark the box which most closely describes your current condition.

1. PAIN INTENSITY

- ☐ I can tolerate the pain I have without having to use pain killers
- ☐ The pain is bad but I manage without taking pain killers
- ☐ Pain killers give complete relief from pain
- ☐ Pain killers give moderate relief from pain
- ☐ Pain killers give very little relief from pain
- ☐ Pain killers have no effect on the pain and I do not use them

2. PERSONAL CARE (e.g. Washing, Dressing)

- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but manage most of my personal care
- ☐ I need help every day in most aspects of self care
- ☐ I don't get dressed, I was with difficulty and stay in bed

3. LIFTING

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, i.e. on a table
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift very light weights
- ☐ I cannot lift or carry anything at all

4. WALKING

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me walking more than one mile
- ☐ Pain prevents me walking more than ½ mile
- ☐ Pain prevents me walking more than ¼ mile
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time and have to crawl to the toilet

5. SITTING

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting more than one hour
- ☐ Pain prevents me from sitting more than ½ hour
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

6. STANDING

- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than one hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

7. SLEEPING

- ☐ Pain does not prevent me from sleeping well
- ☐ I can sleep well only by using medication
- ☐ Even when I take medication, I have less than 6 hrs sleep
- ☐ Even when I take medication, I have less than 4 hrs sleep
- ☐ Even when I take medication, I have less than 2 hrs sleep
- ☐ Pain prevents me from sleeping at all

8. SOCIAL LIFE

- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. dancing, etc.
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

9. TRAVELLING

- ☐ I can travel anywhere without extra pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad, but I manage journeys over 2 hours
- ☐ Pain restricts me to journeys of less than 1 hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from traveling except to the doctor or hospital

10. EMPLOYMENT/ HOMEMAKING

- ☐ My normal homemaking/ job activities do not cause pain.
- ☐ My normal homemaking/ job activities increase my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my homemaking/ job duties, but pain prevents me from performing more physically stressful activities (e.g. lifting, vacuuming)
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pain prevents me from doing even light duties.
- ☐ Pain prevents me from performing any job or homemaking chores.

AUTHORIZATION OF USE/DISCLOSURE OF PROTECTED INFORMATION

Preferred Method of Contact

How would you prefer to be contacted regarding appointments, and/or other information pertinent to your healthcare and/or payment for service provided by the Rosipal Institute for Pelvic Therapy Solutions? (Check all that apply)

- ☐ **Home Phone/voicemail**(_____) _____-_____
- ☐ **Cell #** (_____) _____-_____
- ☐ **Work #**(_____) _____-_____
- ☐ **Email** _____

OK TO LEAVE VOICE MESSAGE-(CIRCLE ONE) **YES*** OR **NO**

OK TO SEND TEXT MESSAGE AND EMAILS - (CIRCLE ONE) **YES*** OR **NO**
*Typically messages are general in nature, and do not mention nature of visit or any specific patient data.

CONSENT TO RELEASE MEDICAL INFORMATION: I authorize Rosipal Institute for Pelvic Therapy Solutions to release any information, verbal and written, acquired in connection with my therapy services including, but not limited to diagnosis, clinical records, to myself, my insurance(s), physician(s), and those listed below:

ADDITIONAL PERSONS AUTHORIZED TO RECEIVE INFORMATION:

_____

Name of person/relation to patient Phone #

_____

Print Patient Name

_____

Signature of Patient Date

Cancellation and No Show Policy:

We understand that all of our patients' time is valuable and there are times when you must miss an appointment due to emergencies or obligations for work or family. However, since we have a very full schedule, when you do not call to cancel an appointment, you may be preventing another patient who is on the waiting list from getting much needed treatment. Because of this we are instituting a **STRICT CANCELLATION POLICY**.

_____ (initial) If you need to reschedule or cancel your appointment, p**lease call us at (972) 735-0920 a minimum of 24 hours prior to your appointment time.**

_____ (initial) **To cancel a Monday appointment, please call our office by Noon on Friday.**

_____ (initial) **A $50.00 fee will be charged if you do not show up for your appointment or are more than 10 minutes late for your appointment.**

_____ (initial) **A $50.00 fee will be charged if you do not cancel at least 24 hours prior to your appointment.**

_____ **(initial) We reserve the right to cancel all future appointments scheduled if you do not show up for 2 or more appointments.**

As a courtesy, our office will make reasonable attempts to send appointment reminders approximately 48 hours in advance via the email address provided. If you are not receiving these emails, please notify the office. Please understand that it is your responsibility to remember your appointment dates and times in order to prevent any missed appointments which result in a cancellation fee. Not receiving an electronic notification of your appointments from us is not sufficient reason to miss an appointment

If you have any questions regarding this policy, please let the staff know.

I have read, understand and agree to comply with the above policies.

_____

Patient Name (Printed)

_____

Signature of Patient Date

FINANCIAL POLICY STATEMENT

IMPORTANT INFORMATION PLEASE READ

The Rosipal Institute has adopted the following financial policy. If after reading this you still have questions, please discuss them with our office manager prior to your first appointment.

We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

FINANCIAL POLICY

All patients must read and sign this form prior to receiving services.

- It is your responsibility to provide us with your most current insurance information in a timely manner and verify that we are a participating provider for your insurance company.

- We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company including any authorization/referral requirements as well as the number of visits your insurance allows for therapy. *If your insurance company denies a claim, for any reason, you will be financially responsible for services rendered.*

- We may accept assignment of insurance after verification of your coverage. Please be aware that some, or perhaps, all of the services provided may not be covered in full by your insurance company. *You are financially responsible for services not covered by your insurance company.*

- Copayments, coinsurance and/or deductibles are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full remaining balance, as determined by your insurance company, once they have paid your claim – regardless of our estimation. Payment in full at the time of service is required for all cash pay patients.

- You must provide your most current billing address, all available telephone numbers and any other important contact information. If your address or contact information changes, it is your responsibility to contact us with the updated information.

- We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30-days after receipt of the initial statement. You can call (972)735-0920.

- Payment in full is due upon receipt of the statement. Patient balances not paid in full within 30 days of the statement issue date are deemed past due. Past due accounts may be subject to a $5.00 monthly late fee and may be referred to a professional collection agency and/or attorney for further collection activity. You will be
- responsible to pay all collection costs incurred, including attorney's fees and court costs if applicable. If you are not able to pay the balance due in full, you must contact our billing office to discuss a payment schedule.

- Failure to keep your account balance current may require us to cancel or reschedule your appointment

- In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add $25 to your original balance. In addition, we may seek all additional legal remedies provided to us under Texas law.

- We understand that all of our patients' time is valuable. If you need to reschedule or cancel your appointment, please do so a **minimum of 24 hours (Mon – Fri business hours)** prior to your appointment. Patients who do not cancel within this time frame will be subject to a fee of $50.00. *We reserve the right to cancel future appointments scheduled if you do not show up for 2 or more appointments.* As a courtesy, our office will make reasonable attempts to send appointment reminders approximately 48 hours in advance via the email address provided. If you are not receiving these emails, please notify the office

I have read and understand this financial policy and agree to abide by its terms. I also understand this policy may be amended from time to time by the Rosipal Institute, with written notice provided to me.

_____

Signature of Patient Date

_____

Printed Name of Patient

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize Rosipal Institute for Pelvic Therapy Solutions to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for related services. I authorize the payment of medical benefits to Rosipal Institute for Pelvic Therapy Solutions. I understand that I am ultimately responsible for all services whether covered by insurance or not. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____

Signature of Patient Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT TO TREATMENT

I hereby consent to receive care for therapy services by Rosipal Institute for Pelvic Therapy Solutions. I consent to medical treatment as is deemed necessary or advisable by the physical therapist.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____

Print Patient Name

_____

Signature of Patient Date