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: _________________

Instructions

We are interested in knowing whether you are having any difficulty at all with the activities listed below **because of your lower limb problem** for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, *do you* or *would you* have any difficulty at all with:

Activities	Extreme difficulty or unable to perform activity	Quite a bit of difficulty	Moderate difficulty	A little bit of difficulty	No difficulty
1. Any of your usual work, housework or school activities.	0	1	2	3	4
2. Your usual hobbies, recreational or sporting activities.	0	1	2	3	4
3. Getting into or out of the bath.	0	1	2	3	4
4. Walking between rooms.	0	1	2	3	4
5. Putting on your shoes or socks.	0	1	2	3	4
6. Squatting.	0	1	2	3	4
7. Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8. Performing light activities around your home.	0	1	2	3	4
9. Performing heavy activities around your home.	0	1	2	3	4
10. Getting into or out of a car.	0	1	2	3	4
11. Walking 2 blocks.	0	1	2	3	4
12. Walking a mile.	0	1	2	3	4
13. Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14. Standing for 1 hour.	0	1	2	3	4
15. Sitting for 1 hour.	0	1	2	3	4
16. Running on even ground.	0	1	2	3	4
17. Running on uneven ground.	0	1	2	3	4
18. Making sharp turns while running fast.	0	1	2	3	4
19. Hopping.	0	1	2	3	4
20. Rolling over in bed.	0	1	2	3	4
Column Totals:	0	1	2	3	4

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