PATIENT REGISTRATION FORM
(Kindly print)

Name: ____________________________________ Date:_________
First *Middle* *Last*

Address: _________________________________

____

____

Home #:________________ Work #:______________ Cell #:_____________

Email: ______________________________________

Date of Birth: ____________ Sex: ____ Marital Status: ________

Social Security#_____________________ Age: _______

Emergency Contact's name and phone: ____

Can we release medical info to this person? Y N

Referring Physician/Person: _____________________________

Primary Care Physician: ___________________ Phone#________________

Have you received physical therapy this year? Y N

If yes, at what facility and for approximately how long? ________________________

Does the patient live at the primary insured address Y N

If No, please provide address and phone #of primary insured:

____

____

_______________________________________ Phone#________________________

Insurance information:

Primary insurance: _______________________ ID and Group #:_______________

Subscriber (Patient/Guardian): ___________________ Relationship: _________________

Subscriber's DOB: ______________ Subscriber's SS# *(required)* _____________

Secondary insurance: ____________________ ID and Group #:_______________

Subscriber: ___________________ Relationship: _________________

Subscriber's DOB: ______________ Subscriber's SS# *(required)* _____________

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<u>If this is due to a work related injury, please complete the following:</u>

Employer: _______________________________ Date of accident: _________

Employer address: ____

Claim #____________________________

Case Manager/contact person: ___________________________ Phone#_________

<u>If this is due to a Motor Vehicle Accident, please complete the following</u>:

Insurance company: ________________________ Claim#: _______________

Insurance address: _________________________ Phone#_______________

Case Manager/Contact Person: ___________________ Date of accident: _________

Attorney *(if applicable)*:_________________________ Phone#__________________

Are you receiving Chiropractic Care Y / N

If you are receiving Chiropractic care please schedule your physical therapy appointments on separate days. Motor Vehicle insurance does NOT allow for a person to have Chiropractic and Physical Therapy services on the same day. Thank You

CONSENT FOR TREATMENT AND ASSIGNMENT OF BENEFITS

Insurance Customers:

I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist, and/or physician may be considered necessary or advisable while a patient at Joint Motion, L.L.C. Physical Therapy. I consent to the use of my otherwise protected health information for my treatment, Joint Motion practice operations, and to secure insurance reimbursement. I understand that I will be treated in an open air environment and limited personal information may be unavoidable disclosed. I request that payment of authorized benefits be made on my behalf to:
Joint Motion, L.L.C.
373 Park Ave
Scotch Plains, NJ 07076
For any services furnished to me by Joint Motion, L.L.C. Physical Therapy. I authorize any holder of medical information about me to release to my insurance company(ies) and its agents any benefits payable for related services. I hereby authorize my insurance company(ies) to furnish to the above named therapist any information regarding my insurance claims under Title XVIII of the Social Security Act. I also am aware that I may be responsible for any charges that my insurance company denies payment for service as "not medically necessary."
A copy of this signature is as valid as the original.

Signature (Patient/Guardian): ____________________________

Witness (Joint Motion Staff): _____________________________ Date: __________

Self-Pay Customers ONLY:

This is to certify that I am financially responsible to Joint Motion, LLC for services rendered to me. I also authorize payment directly to Joint Motion, L.L.C. benefits otherwise payable to me but that do not exceed the charges stated.
Per Visit Charge: $_____________ Initial_____

Name of Patient: ____

Signature (Patient/Guardian): ____________________________

Witness (Joint Motion Staff): _____________________________ Date: __________

Acknowledgement of Receipt or Privacy Practices:

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. You have the right to review our Notice and ask questions about our privacy practices. The terms of our notice may change. Upon request a copy of our revised notice will be made available to you.

By signing this form, you acknowledge that you have received our Notice of Privacy Practices

Name of Patient ____

Signature (Patient/Guardian) ____

<u>Notification of Appointment Alert Systems</u>
Our office utilizes both a text or voice alert system to notify you of upcoming appointment dates and times. Medical information specific to your care and treatment will <u>not</u> be shared via the automatic alert system. Unless you choose differently below, the default selection is via text alert to your mobile phone number. You may opt of this alert system at any time. If you choose to do so, please notify our front office personnel either verbally or in written form at your earliest convenience.

Please select your preference:

☐ I prefer a Text Alert only: (Cell number will be default) preferred phone if other #________________

☐ I prefer a Voice Alert to phone number: __________________ only

☐ I prefer to opt out and not receive an alert.

* Please review our cancellation/no show policy. Note, we reserve the right to charge a fee for appointments cancelled/missed without 24 hours prior notification.

** To ensure that we provide you with the best care possible, <u>within a 1-week notice</u>, kindly provide our office staff with your future doctor's appointment information. In doing so, this will help maintain good communication between our office and your medical providers.

By signing this form, you acknowledge that you have read our Appointment Alert System Notice

____
Name of Patient

____
Signature of Patient/Guardian

<u>Blood Flow Restriction Consent:</u>

I understand the risk and contraindications to this procedure and agree to participate in Personalized BFR Rehab techniques as an adjunct to my current treatment. **THERE IS A ONE TIME, NON-INSURANCE BILLABLE CHARGE OF $10 for the PERSONAL SANITARY COMPRESSION GARMENT to be used during this treatment if I choose to consider it. _____ Initial**

Signature (Patient/Guardian): ____________________________

Witness (Joint Motion Staff): _____________________________ Date: _________

HIPAA Authorization for Use and Disclosure of PHI for Marketing and/or Promotional Purposes:

I authorize Joint Motion, L.L.C. , and its employees, agents, and authorized representatives, to use and/or disclose my Protected Health Information contained in any photograph(s), videotape(s), medical and physical therapy records, and/or audio recording for the following purposes:

- Use in internal and external advertising, marketing, public relations or collateral materials, including but not limited to posting on Joint Motion, L.L.C. 's website and social media sites.

- Use in news releases or stories, including television, newspaper, or radio broadcasts.

- Use in internal and external education and/or training programs for the public and/or medical professionals, including but not limited to use on public websites and social media sites.

I further authorize Joint Motion, L.L.C. to disclose my Protected Health Information to E-Rehab, LLC, a limited liability corporation formed under the laws of California, for use and disclosure in connection with creating promotional and educational videos, news releases or stories, and other promotional or public relations materials being created or managed by that entity for use in promoting physical therapy on its websites.
I understand that the Protected Health Information I am authorizing Joint Motion, L.L.C. to use and/or disclose may include my name and contact information, demographic information, health information, treatment information, and information about my health care services, except as specifically described as follows (please describe if applicable):________________________________
____
____.

I provide my authorization knowing that:

- I understand that Protected Health Information that is used or disclosed pursuant to this authorization, including Protected Health Information contained in any photographs, videotapes, or interviews, may be subject to re-disclosure by the recipient(s) and may no longer be protected by HIPAA or other state or federal laws.
- I understand that signing this authorization is voluntary. I have the right to refuse to sign this authorization.
- My treatment, payment, enrollment in a health plan, or eligibility for benefits is not conditioned on my provision of this authorization.
- I understand that I can revoke or cancel this authorization at any time by sending written notice to:

Joint Motion, L.L.C.
Attn: Triston Glynos
373 Park Avenue
Scotch Plains, NJ 07076

- If I revoke or cancel this authorization, I understand that the revocation will not apply to Protected Health Information that has already been used or disclosed in reliance on my authorization.

Signature (Patient/Guardian): ____________________________

Witness (Joint Motion Staff): ______________________________ Date: __________

“We DO MORE of what we love…so you can DO MORE of what you love."

MEDICAL SCREEN FORM

Name:			Date of Birth:	
Height (in inches):	Weight:	Age:	Gender: **M / F**	Smoker: **Y/N**
Are you pregnant(Females): **Y/N**	Occupation:		Work status: Full/Modified/Not Working	

PAST MEDICAL HISTORY Have you or a family member EVER been told that you have or had:

You Family ↓ ↓	You Family ↓ ↓	You Family ↓ ↓	You Family ↓ ↓
❑ ❑ Allergies/Asthma	❑ ❑ Heart Disease	❑ ❑Mental Illness	❑ ❑Sexually Transmitted Dis.
❑ ❑ Angina/Chest Pain	❑ ❑High Blood Pressure	❑ ❑ Neurological Disease	❑ ❑ Stroke/TIA
❑ ❑ Blood Clot/DVT	❑ ❑High Cholesterol	❑ ❑ Osteoarthritis	❑ ❑ Ulcers
❑ ❑ Cancer(specify below)	❑ ❑Kidney Disease	❑ ❑ Osteoporosis	❑ ❑ HIV/AIDS
❑ ❑ Diabetes	❑ ❑Liver Disease	❑ ❑ Rheumatoid Arthritis	❑ ❑Autoimmune Disease
❑ ❑ Fibromyalgia	❑ ❑Lung Disease	❑ ❑ Seizure/Epilepsy	❑ ❑ Allergies-Pets
OTHER:			

Have you had a recent illness or infection? ☐ YES ☐ NO If yes please explain___________________________________
Do you take blood thinners? ☐ YES ☐ NO
Are you allergic to latex or adhesives? ☐ YES ☐ NO
During the past month, have you been bothered by feeling down, depressed or hopeless? ☐ YES ☐ NO
During the past month, have you been bothered by little interest or pleasure in doing things? ☐ YES ☐ NO If yes, Is this something in which you would like help? ☐ YES ☐NO ☐ Yes but not today
Has your weight changed significantly since your symptoms began? ☐ YES, unsure why ☐ YES, I know why ☐ No
In the past 12 months, have you fallen? ☐ YES ☐NO If yes, how many times? ____ Did it cause an injury? ☐ YES ☐NO
Have you had any problems with bowel or bladder functioning (incontinence, etc) ☐ YES ☐ NO

PAST RELEVANT or RECENT SURGICAL HISTORY

Surgery: ____ Date: ______________

Surgery: ____ Date: ______________

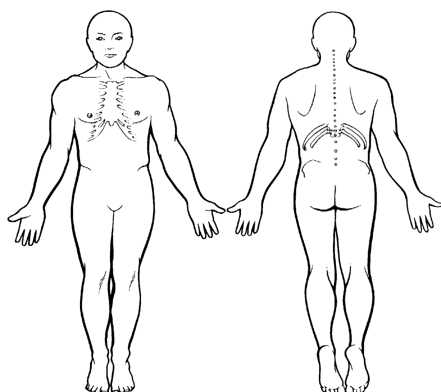
MEDICATIONS (Name, Dosage and Frequency)
☐ see attached list (please provide a list if checking this line)

CURRENT SYMPTOMS
Where are you currently having symptoms? **Body Region(s)** : ☐Right ☐Left ☐ Both
What date (approximately) did your present pain start?
How did it begin? (gradually, suddenly, injury)
My symptoms are currently (circle one): GETTING BETTER ABOUT THE SAME GETTING WORSE
Have you received any type of treatment for this problem (Injections, PT, Chiropractic, Acupuncture, Etc)? ☐ YES ☐ NO
Have you ever had this problem before? ☐ YES ☐ NO
If yes, how was the problem treated?

MEDICAL SCREEN FORM

How long did it take you to feel better?
For your current problem, have you had an x-ray, MRI, or other imaging study? **Y/N**, if yes, which& results?
How are you able to sleep at night? (circle one) WELL MODERATE DIFFICULTY ONLY WITH MEDICATION
Does coughing, sneezing or taking a breath make your symptoms worse? ☐ YES ☐ NO
Does eating certain foods change your symptoms? ☐ YES ☐ NO
Have you recently experienced (Please circle any that apply) :Nausea/Vomiting/Fever/Chills/Sweats/Extreme Fatigue ☐ YES ☐ NO
What makes your symptoms better?
Please circle the activities that make your pain worse: Lying Down Sitting Standing from a sitting position Prolonged Standing Lifting Gripping Walking Stress Reaching Stairs Other:____
Please list the best and worst time of day for your symptoms BEST________________ WORST______________________
What is your personal goal for therapy?

BODY CHART: Please mark the areas where you feel pain on the chart below



For the therapist
+ / - Cough/Sneeze
+ / - Saddle Anesth.
+ / - Bwl/Blddr Chnge
+ / - Numb/Ting.

On the scales below, please circle the number which best represents the severity of your pain in general:

Average for the last 48 hours: 0 (No Pain) 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)

Best for the last 48 hours: 0 (No Pain) 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)

Worst for the last 48 hours: 0 (No Pain) 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)

Please circle the number below which best represents your overall average level of function.

0 (Cannot do anything) 1 2 3 4 5 6 7 8 9 10 (Able to do everything)

Aggravating Factors: Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem. List them below:

1)____

2)____

3)____

Below for therapist :
Rating: _____
Rating: _____
Rating: _____

For Therapist Use	*Patient Specific Functional Scale Avg:* ______________
	Score for SPPB/ QDASH/ LEFS/ NDI/ODI/BERG : _____________

CONSENT: I understand that my diagnosis & treatment plan will be discussed during my appointment and that I have the right to question and/or refuse any treatment offered.

Signature____Date_____________ Therapist initials___________