LEVAN PHYSICAL THERAPY

15132 LEVAN ROAD, LIVONIA, MI 48154

PATIENT REGISTRATION

(Please Print)

Date:	**Patient Account Number:**

PATIENT INFORMATION

Last:	**First:**	**Middle:**	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	**Marital status (circle one)** Single / Married / Wid

Is this your legal name? If no then name? ❑ Yes	**Email:**	**Birth date:**	**Age:**	**Sex:** ❑ M ❑ F

Social Security #	**Home phone#**	**Work/cell#**

Street address:	**City:**	**State:**	**ZIP Code:**

Occupation:	**Employer**	**Employer phone#**

Referred to clinic by (please check one box):	❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Physician :	**Phone:**	**Fax:**

Street Address:	**City:**	**State:**	**Zip Code:**

(Please give your insurance card and photo ID to the receptionist.)

Person responsible for bill:	**Birth date:**	**Address (if different):**	**Home phone#**

Is this person a patient here?	❑ Yes ❑ No

Is this patient covered by insurance?	❑ Yes ❑ No

Please indicate primary insurance					
Subscriber:		**Subscriber's Birth date:**	**Claim #**	**Policy #**	**Co-payment/Ded:**

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):			**Policy #**

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

EMERGENCY CONTACT INFORATION

Name of local friend or relative:	**Relationship to patient:**	**Home phone#**	**Work phone #**

Patient/Guardian Signature _____ ***Date*** _____

Please turn over to complete the form

LEVAN PHYSICAL THERAPY, PLLC

15132 LEVAN ROAD
LIVONIA, MI 48154
TEL: 734-462-1703
FAX: 734-462-1744

In consideration of your undertaking to treat me, I agree to the following:

AUTHORIZATION TO RELEASE INFORMATION

You are authorized to release my medical records to any insurance company, attorney, physician, adjuster and consultant, in order to process any claim(s) for reimbursement of charges or other legal purposes as a result of the professional services rendered by you and I hereby release you of any consequences thereof.

ASSIGNMENT OF ACTION

In the event of any insurance company is obligated by contractual agreement to make payment to me or you for the demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is/are believed to be correctly set forth under pertinent data below) and authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company (or companies) contractually obligated, you will refrain from attempts and efforts to collect the amounts you do not collect from insurance proceeds (whether it be all or part of what is due), I personally owe you and agree to pay in a current manner.

AUTHORIZATION TO PAY DIRECTLY TO THERAPIST

In consideration of Physical and Occupational therapy services rendered and to be rendered by them, I authorize and direct the payment to **LEVAN PHYSICAL THERAPY, PLLC** of any sum I now or hereafter owe them by you, my attorney, out of the proceeds of any settlement of my case and/or by any insurance company obligated in whole or in part upon the charge made for his services.

ACKNOWLEDGMENT AND UNDERSTANDING

I hereby acknowledge that I am receiving (or about to receive) care services at **LEVAN PHYSICAL THERAPY, PLLC** and that I have been advised that therapist providing the services is willing to wait for payment of these services, provided that there continues to be a reasonable chance that payment will be made either by the insurance proceeds or out of the settlement of liability case.

I understand that if it is determined either:

1. That there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the therapist; or make provision for protection of the interest of the therapist.
2. If a liability claim exists and my attorney refuses to agree to protect the interest of the therapist; or if I have not engaged in services of an attorney.

Then payment of the services rendered by the therapist at Levan Physical Therapist, PLLC will be made on a current basis and by bill paid in full as my liability claim is settled or the passage of three months from my last treatment, whichever occurs first.

Dated the _____day of _____

Patient Signature_____

Witness: _____ Date _____

Levan Physical Therapy

151232 Levan Road
Livonia, MI 48154

HOME HEALTH DISCLAIMER FOR MEDICARE PATIENTS

I understand that at the time of receiving therapy services from Levan Physical Therapy, I am not allowed to have Home Health Service per Medicare policies. If my bills were not paid due to my home health episodes, then I am responsible for the payments.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Levan Physical Therapy, may use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and healthcare Operations (TPO). Please refer to Notice of Privacy Practices for Levan Physical Therapy for a more complete description of such uses and disclosures.

I understand that I have the right to review the Notice of Privacy Practices prior to signing this consent. And, that Levan Physical Therapy reserves the right to revise its Notice of Privacy Practices any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Levan Physical Therapy, 15132 Levan Road, Livonia, MI 58154.

With my consent, Levan Physical Therapy may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results and prescriptions, among others.

With my consent, Levan Physical Therapy may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, Levan Physical Therapy may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Levan Physical Therapy restrict how it uses or discloses any PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Levan Physical Therapy use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my consent. If I do not sign this consent, Levan Physical Therapy may decline to provide treatment to me.

_____

Patient's Name

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Name of Patient or Legal Guardian

LEVAN PHYSICAL THERAPY

PATIENT SELF-ASSESSMENT

Patient Name_____ Ht_____ Wt_____ Date of Birth_____

Describe your symptoms _____

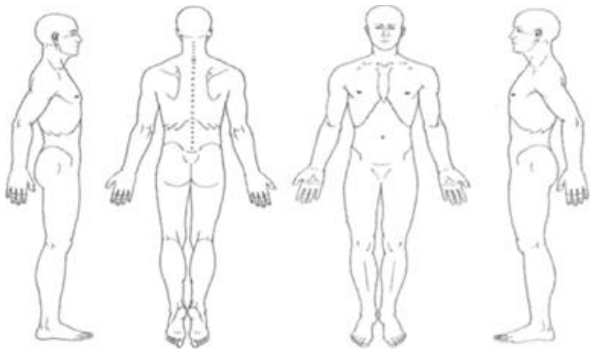
When did your symptoms begin? _____ How did they begin? _____

Is this an Auto Accident? _____Yes_____No, If yes – Date of accident _____

Is this employment related? _____Yes_____No, If yes, Date of occurrence _____

Do you have an Attorney? _____Yes _____ No, Attorney Name & Phone # _____

Indicate where you have pain or other symptoms



None Unbearable

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

1. Have you had physical therapy or other treatment for this problem in the past? Yes_____ No_____
   If yes, where and what were the results of the treatment? _____
   _____
   _____
2. Have you had any diagnostic testing for this problem (X-ray, CT Scan, EMG, MRI, Other)
   _____
   _____
   _____
   _____
3. List medications you are currently taking, include over-the counter, homeopathy and vitamins
   _____
   _____
   _____
   _____

<u>Please turn over to complete self-assessment form</u>.

4. List past surgeries, serious illnesses or accidents:

_____
_____
_____
_____
_____

5. Do you a. Consume alcohol _____ How many glasses? _____
   b. Smoke _____ How many daily? _____
   c. Use caffeine _____ How much? _____ Feel tired often _____

6. Recreational activities you like to do:

_____
_____
_____

7. List physical requirements for work / Play

_____
_____
_____

8. Are you pregnant? _____Yes_____No

9. Please check all that apply to you:

□ High Blood Pressure	□ Heart Disease
□ Diabetes	□ Eyes, Ears, Nose Throat
□ Cancer/Malignancy	□ Hormonal Problem
□ Headaches	□ Genito-Urinary problem
□ Mental/Nervous Disorder	□ Irregular Heart Beat
□ Gout	□ Pain Upper Lower Back
□ Respiratory/breathing problems	□ Head, Knees, Ankles, Feet
□ Epilepsy	□ Pain Neck Shoulders Hips Jaw
□ Ulcer/digestive Disorder	□ Chest Pain
□ Reconstructive surgery/implants	□ Birth Defect
□ Pacemaker	□ Wear shoe inserts, mouth bite, splints/braces

□ Other _____
□ Other _____

This information is true and accurate to the best of my knowledge at the present time.

_____ ____/____/_____
Patient Signature Date