TRI-CARE Physical Therapy

24100 Warren Dearborn Heights, MI 48127
(313) 434-6000

Patient Registration Form

Personal Information

Name:		Name you prefer:
Home Address:		Apt #
City:	State:	Zip Code:
Mailing Address:		
City:	State:	Zip Code:
Injury/ Diagnosis:		Home Phone:
Date of Injury/Onset of symptoms:		Work Phone:
Date of Birth:	Age:	Cell Phone:
Email Address:		
Emergency Contact:		Emergency Contact Phone #:
How did you hear about us?:		

Referring Physician Name:		Phone #:
City, State:		
Primary Care Physician Name:		Phone #:
City, State:		
Employer Name:		Occupation:
Address:		City, State:
Social Security Number (For Insurance Benefit Verification):		

Primary Insurance Information

Is this an auto accident?:	Yes	No	Is this a worker's comp case?:	Yes	No
If "Yes", list claim # and adjuster contact information:					
Health Insurance Company Name:					
Subscriber's Name:			Subscriber's Date of Birth:		
Relationship to the Subscriber:					
Subscriber's Address and Phone # if different from patient:					
Address:					
City, State		Zip		Phone#	

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Consent to Treatment

I hereby authorize the professional staff at Tri-Care Physical Therapy to examine and treat me with physical therapy for the injury I have been referred here for or referred myself to.

Patient Signature	Printed Name	Date
Parent or Guardian Signature (if under 18)	Printed Name	Date

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO HEALTH PROVIDER

Insurance Company/Companies Name(s) _____

I hereby instruct the above named insurance company/companies to pay by check made out to and mailed directly to: ***Tri-Care Physical Therapy*** for professional/medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for services rendered.
THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.
This payment will not exceed my indebtedness to the above mentioned assignee and I agree to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment as required by my insurance policy.

Patient Signature	Printed Name	Date
Parent or Guardian Signature (if under 18)	Printed Name	Date

Notice of Privacy Practices

I hereby authorize that I am aware of my rights as it pertains to HIPAA and my Protected Health Information (PHI). Tri-Care Physical Therapy has offered me a copy of their Notice of Privacy Practices for my own records.

If there is anyone you would like to authorize the disclosure of your PHI, medical or billing, you may specifically name the party below and indicate what information you would like to disclose:

1. _____ ☐entire medical record ☐diagnosis & medical treatment ONLY ☐billing ONLY

2. _____ ☐entire medical record ☐diagnosis & medical treatment ONLY ☐billing ONLY

Patient Signature	Printed Name	Date
Parent or Guardian Signature (if under 18)	Printed Name	Date

Staff Witness Initials:_____

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Medical History Information Sheet

1. What would you say is the pain rating for your current condition using a scale of 0 – 10? (0=no pain, 10=worst pain imaginable) _____

2. Do you now or have you ever had the following?

			Explain
Stroke	*yes*	*no* _____	_____
Heart Disease or Heart Murmur	*yes*	*no*	_____
High Blood Pressure	*yes*	*no* _____	_____
Asthma	*yes*	*no* _____	_____
Diabetes	*yes*	*no* _____	_____
Epilepsy/Fainting	*yes*	*no*	_____
Impairment of Vision or Hearing	*yes*	*no*	_____
Cancer	*yes*	*no* _____	_____
Drug Allergies	*yes*	*no* _____	_____
Osteoporosis	*yes*	*no* _____	_____

Orthopaedic History – Please give dates & treatments received:

3. Have you ever sprained, strained, dislocated or fractured the following:

   Neck/Head (including concussion) _____

   Trunk (ribs, vertebrae, sternum) _____

   Low Back (vertebrae, discs, nerves) _____

   Upper Extremity (shoulder, elbow, wrist, arm) _____

   Lower Extremity (hip, leg, knee, ankle, foot) _____

4. Please list any surgeries that you have had and their dates:
   _____

5. Please list medication(s) presently taking: _____

6. Women: Are you pregnant? yes _____ no _____

7. Have you ever had PT in the past?_____
   If so, when? _____

8. **IF YOU HAVE MEDICARE, HAVE YOU EVER HAD HOME HEALTH CARE?**_____

9. If so, what is the **name and phone number** to the agency? _____

I agree that the above information accurately describes my medical history and that should any changes in my medical history occur, I will notify my PT immediately

Signature_____date:_____

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Missed Appointment Policy

We strive to provide our patients with excellent service and quality care. Our commitment to your well-being and health care is something that we at *Tri-Care Physical Therapy* take very seriously.

Your commitment to your physical therapy program is critical to your success. We will recommend treatment and set goals for you. In order to reach those goals you must do your part and your most important part is to make each and every appointment.

We will give you an appointment card to keep track of your appointments. If you should misplace this, please give us a call to review your appointment dates. We expect you to keep all your appointments; however should you need to cancel please note that we require a **24-hour notice**.

If you miss **3** consecutive appointments we will notify your physician and will require a new referral in order to continue your treatment.

We thank you for choosing *Tri-Care Physical Therapy* and we are looking forward to working with you and helping you reach your goals.

The Staff at Tri-Care Physical Therapy

I have read and understand this policy.

_____ _____

Patient/ Guardian Date

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Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow **Tri-Care Physical Therapy** to use their Patient Health Information (PHI) for purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow **Tri-Care Physical Therapy** to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The Patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in the office.
4. The patient may provide a written request to revoke consent to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designate to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purposes of treatment, payment and health care operations, __ has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ __/__/____

Patient Signature Date

TRI-CARE Physical Therapy

24100 W. WARREN, DEARBORN HEIGHTS, MI 48127

PH: 313-434-6000 FAX: 313-427-8166

Letter of Lien

TO: (Your attorney's name) _____ _

Re: (Your name) _____ _

I do hereby authorize **Tri-Care Physical Therapy, LLC** to furnish you, my attorney, with a full report of the examination, treatment, prognosis, etc., of myself in regard to the accident in which I was involved occurring on or about ____/_____/_____.

I hereby give a non-revocable lien to **Tri-Care Physical Therapy, LLC** on my settlement, claim, judgment, or verdict as a result of aid accident, and authorize and direct you, my attorney, to pay **Tri-Care Physical Therapy, LLC**, such sums as maybe due and owing **Tri-Care Physical Therapy, LLC** for services rendered to me, and to withhold such sums from any settlement, claim, judgment or verdict as may be necessary to protect **Tri-Care Physical Therapy, LLC.**

I fully understand that I am directly and fully responsible to pay **Tri-Care Physical Therapy, LLC** for all medical bills submitted by **Tri-Care Physical Therapy, LLC** for services rendered me, and this agreement is made solely for **Tri-Care Physical Therapy, LLC** protection and in consideration of awaiting payment.

This non-revocable lien is binding on the patient and his or her attorney or agent with or without acknowledgement of patient's attorney.

Date: _____ Patient's signature _____ _

Date: _____

Patients Legal Guardian (if applicable) /relationship to patient.

This undersigned, being attorney of record for the above patient, does hereby agree to honor this lien.

Date: _____ _ Attorney's Signature: _____

NOTE: Please Date, sign, and return one copy to **Tri-Care Physical Therapy,** LLC at the above address or fax.