Delray Care PHYSICAL THERAPY
"The results you want. The CARE you deserve."

2645 N Federal Highway
Suite 240
Delray Beach, FL 33483
561-562-8561 Fax 561-562-8563

PATIENT REGISTRATION

PLEASE PRINT

PATIENT INFORMATION

LAST NAME	FIRST	MI	DATE OF BIRTH	SOCIAL SECURITY	SEX

LOCAL ADDRESS APT #	CITY	STATE	ZIP CODE

HOME PHONE ( )	CELL PHONE ( )	MARITAL STATUS SINGLE ( ) MARRIED ( ) OTHER ( )

EMAIL ADDRESS

SEASONAL HOME ADDRE APT #	CITY	STATE	ZIP CODE

EMPLOYMENT STATUS EMPLOYED( ) FULL TIME STUDENT( ) PART TIME STUDENT( ) RETIRED (	EMPLOYER NAME	TITLE / POSITION

WORK ADDRESS	CITY	STATE	ZIP CODE	WORK PHONE

IN CASE OF EMERGENCY CALL

NAME	TELEPHONE ( )	RELATIONSHIP

REFERRING PHYSICIAN INFORMATION

REFERRING PHYSICIAN	TELEPHONE ( )	PRIMARY PHYSICIAN	TELEPHONE ( )

REASON FOR TODAY'S VISIT

PLEASE DESCRIBE INJURY / ACCIDENT / ILLNESS:

IS THIS CONDITION RELATED TO WORK: YES ( ) NO ( )	IS THIS CONDITION RELATED TO AN AUTOMOBILE ACCIDENT: YES ( ) NO ( )	PLEASE INDICATE THE DATE OF INJURY/ACCIDENT:

PLEASE PROVIDE NAME OF INSURANCE ADJUSTER OR CONTACT:	TELEPHONE ( )

PRIMARY INSURANCE COMPANY INFORMATION

PRIMARY INSURANCE COMPANY NAME	IDENTIFICATION NUMBER	GROUP NUMBER

POLICYHOLDER (if other than patient)	RELATIONSHIP	DATE OF BIRTH

SECONDARY INSURANCE COMPANY INFORMATION

SECONDARY INSURANCE COMPANY NAME	IDENTIFICATION NUMBER	GROUP NUMBER

POLICYHOLDER (if other than patient)	RELATIONSHIP	DATE OF BIRTH

DO YOU CURRENTLY HAVE A LEGAL CASE PENDING FOR THIS CONDITION / INJURY: YES ( ) NO ( )

ATTORNEY NAME:	ATTORNEY ADDRESS:	ATTORNEY PHONE NUMBER:

ASSIGNMENT OF BENEFITS / AUTHORIZATION TO RELEASE MEDICAL INFORMATION / CONSENT TO TREATMENT

I HEREBY AUTHORIZE DIRECT PAYMENT OF MEDICAL BENEFITS TO DELRAY CARE PHYSICAL THERAPY, LLC. FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF SAID BENEFITS. A COPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. I AUTHORIZE THE REHABILITATION TEAM TO PERFORM THE TREATMENTS OR PROCEDURES APPROVED BY MY REFERRING PHYSICIAN. I ACKNOWLEDGE THAT NO GUARANTEES, EITHER EXPRESSED OR IMPLIED HAVE BEEN MADE TO ME REGARDING THE OUTCOME OF ANY TREATMENTS AND/OR PROCEDURES. I FULLY UNDERSTAND THAT IT IS IMPOSSIBLE TO MAKE ANY GUARANTEES REGARDING THE OUTCOME OF ANY MEDICAL TREATMENT OR PROCEDURE. I ATTEST THAT ALL OF THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

AUTHORIZED SIGNATURE: X	**TODAY'S DATE:** / /

IS THERE SOMEONE WE ARE ABLE TO THANK FOR REFERRING YOU TO OUR FACILITY? IF SO, PLEASE PROVIDE NAME:

Medical History Questionnaire

Name	DOB	Age

Height _____Ft _____ inches	Weight

Are you currently receiving ***any*** services at home? ☐ No ☐ Yes- Please explain

Reason for Therapy	Date of Injury, Onset or Surgery
When is your next appointment with your referring physician?	Could you be or are you pregnant? ☐ No ☐ Yes

Have you had any falls in the past year? ☐ No ☐ Yes If so, how many?

Did you sustain any injuries due to fall(s)? ☐ No ☐ Yes - Please explain

Do you currently take Vitamin D supplement? ☐ No ☐ Yes

Do you have any allergies? ☐ No ☐ Yes, list allergies:

Do you now or have you ever had any of the following? Please check box if applicable.

Alzheimer's ☐	Head Injury / Concussion ☐	Previous Fractures ☐
Anemia ☐	Headaches ☐	Recent Weight Loss or Gain ☐
Anxiety ☐	Hearing Loss ☐	Seizures / Epilepsy ☐
Arthritis ☐	Heart Attack ☐	Shortness of Breath ☐
Asthma ☐	Heart Disease ☐	Spinal Cord Stimulator or any other device ☐
Cancer or Tumor ☐	Hepatitis ☐	Stroke ☐
Chest Pain / Discomfort ☐	Hernia ☐	Swelling in Ankles ☐
Chronic Cough ☐	High Blood Pressure ☐	Thyroid Problems ☐
Current Infections ☐	Hypersensitivity to Heat/Cold ☐	Tuberculosis ☐
Dementia ☐	Kidney / Bladder Problems ☐	Vascular Disease ☐
Deep Vein Thrombosis ☐	Metal in Body or Surgical Implants ☐	Other ☐
Diabetes ☐	Osteoporosis ☐	
Fainting Spells ☐	Pacemaker ☐	

Do you engage in physical activities regularly? If so, what and how often?

Are you presently taking any medications? ☐ No ☐ Yes, list any medications, dosage and specify frequency:

Drug Name:	Dosage:	Frequency:
Drug Name:	Dosage:	Frequency:
Drug Name:	Dosage:	Frequency:
Drug Name:	Dosage:	Frequency:

At the present time, would you say that your health is (check one): Excellent Very Good Fair Poor

The information is correct and to the best of my knowledge.

Patient/Guardian Signature	Date
Therapist Signature	Date

Delray Care Physical Therapy, LLC.

DESIGNATED INDIVIDUALS AUTHORIZATON FORM

I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

_____
Patient Name

_____
Patient/Guardian Signature

_____
Date

Patient Authorization

Patient Name: Date of Birth:

Release of Information & Consent for Treatment

All information provided herein is true and correct.
I am aware of my diagnosis and wish to receive treatment at Delray Care Physical Therapy, LLC. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to Delray Care Physical Therapy, LLC to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it pertains to my treatment or payment for services provided.

I authorize Delray Care Physical Therapy, LLC to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

The signature below certifies that I have read and understand the above information. **Initial:** _____

Assignment of Benefits

I authorize payment directly to Delray Care Physical Therapy, LLC for services. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

Initial: _____

Notice of Privacy Practices (HIPPAA Acknowledgement/Consent)

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Delray Care Physical Therapy, LLC.

In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations.

Initial: _____

Payment Guarantee

I agree to pay Delray Care Physical Therapy, LLC, for services provided to me or the party named above. If any law, such as worker's compensation, or insurance contract prohibits payment for these services, I will cooperate and assist in the provision of information, authorizations, releases, or any type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

The benefit verification is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage/payment. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment of services.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of Delray Care Physical Therapy, LLC.

Initial: _____

Patient or Guardian Signature: Date: