PATIENT REGISTRATION FORM

Welcome to our center. In order to serve you properly, we will need the following information. **(PLEASE PRINT)**

Patient's Name	**Sex** M ( ) F ( )	**Birth Date** _____/_____/_____ **Age** _____	**Marital Status** Single ( ) Married ( ) Widowed ( ) Divorced ( )
Residence address City	**State Zip**	**Home Phone** ( ) -	**Patient's Social Security#** - -
Person financially responsible for this account	**Self ( )** **Spouse ( )**	**Responsible Party's Birth Date** ____/____/____	**Responsible Party's Social Security#** - -
Responsible party's Drivers License# State Number	**Occupation**		**How long at the current employer?**
Name of Employer Address			**Business Phone Number**
Referred by: (include address and phone number)			
Person to contact in case of emergency:	**Phone number**	**Relationship to patient**	
INSURANCE **INFORMATION**			
Medicare YES ( ) NO ( )	**MEDICARE#**		**Effective Date**
Secondary Insurance Name Address		**Policy#** **Group#**	**Effective Date**
Subscriber's Name	**Address**		**Phone Number**
Subscriber's Date of Birth **Subscriber's Social Security Number**		**Relationship to patient**	
Worker's Compensation	**Date of Accident** **Claim number**	**Carrier's name and address**	**Carrier's phone number** **Authorization number**
Personal Injury Accident YES ( ) NO ( )	**Date of Accident** **Claim number**	**Carrier's name and address**	**Carrier's phone number** **Authorization number**
Attorney's Name	**Phone number**	**Address**	

Assignment of Benefits / Information Release / Authorization to Treat:

I authorize payment of medical benefits for any services furnished. I understand that I am financially responsible for any amount not covered by my insurance carrier. I authorize you to release to my insurance company or its agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

I also authorize the interdisciplinary 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 have received a copy of my Patients Rights and Responsibilities and this facility's Grievance Procedure.

_____ _____
Patient's signature Date

_____ _____
Patient's Parent, Guardian's Signature (if child is under 18 years old) Date

Patient Consent Form
Notice of Privacy Practices

Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we make the Notice available to you.

When you sign and date this form you are agreeing that you were given a copy of this notice.

The notice states that we may use and disclose protected health information about you for your treatment, payment, and healthcare operations. In your notice, there is a complete list of examples of how we may use to disclose your personal health information without specific authorization from you.

Do we have your permission to:

Leave a message on your answering machine at home?	Yes	No	
Leave a message with someone at home? With whom:_____	Yes	No	
Leave a message at your place of work?	Yes	No	N/A

Other than your doctor, please list full name and relationship
of individual with whom we may discuss your medical condition:

_____

Patient Name: _____

Patient/patient representative Signature:

_____ _____

Signature Date

Summary of Patient's Rights and Responsibilities

We are committed to serving you with compassion, care, skill and respect. As one of our patients, you have choices, rights and responsibilities.

You have the *RIGHT:*

- To be treated with dignity and respect
- To know the names and professional status of people serving you
- To privacy
- To confidentiality of your records
- To receive accurate information about your health-related concerns
- To know the effectiveness, possible side effects and problems of all forms of treatment
- To participate in choosing a form of treatment
- To receive education and counseling
- To consent to, or refuse, any care of treatment
- To select and or change your health care provider
- To review your medical records
- To information about services and any related costs

You also have the *RESPONSIBILITY*

- To seek medical attention promptly
- To be honest about your medical history
- To ask about anything you do not understand
- To follow health advice and medical instructions
- To report any significant changes in symptoms or failure to improve\to respect clinic policies
- To keep appointments or cancel I advance\to seek non-emergency care during regular business hours
- To provide useful feedback about services and policies

_____ _____

Signature Date

MEDICAL HISTORY FORM

ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL

PLEASE TELL US A LITTLE ABOUT YOUR SYMPTOMS

Age: _____

Do you get short of breath? ☐ yes ☐ no

Activities that cause the shortness of breath:

- ☐ Walking
- ☐ Climbing Stairs
- ☐ Lying Down
- ☐ Cooking
- ☐ Dressing
- ☐ Gardening
- ☐ Exercising
- ☐ Carrying thing such as Groceries, laundry
- ☐ Talking
- ☐ Cleaning
- ☐ Personal Hygiene
- ☐ Other: _____

Are you currently having Physical Therapy anywhere? ☐ Yes ☐ No

Do you have pain or weakness in your: (please check all that apply):

- ☐ Neck
- ☐ Back
- ☐ Upper Extremities (Shoulders, Wrists)
- ☐ Lower Extremities (Hips/Legs, Knees, Ankles/Feet)

Are you currently getting Home Health Services? Does a nurse come to your house? ☐ Yes ☐ No

Current Living Environment:

Do you live: ☐ Alone; ☐ With Spouse; ☐ With Family Member; ☐ With Friend

Living in a ☐ single level home; ☐ double or-tri-level home; ☐ Apartment; ☐ Assisted Living

Do you have stairs in your home; ☐ yes (how many) _____ ☐ No

Who does the cooking, cleaning, laundry and shopping in your home: _____

Do you use Oxygen? ☐ Yes ☐ No Name of Oxygen Provider:_____

- ☐ All the time
- ☐ At home only
- ☐ Most of the time
- ☐ At night only

Have you been hospitalized in the past year? ☐ No ☐ Yes

(If yes, please describe including approximated dates, reason for hospitalization)

_____

_____

_____

Are you now taking any medications including non-prescription medication? Please list below.

_____

_____

_____

_____

Patient Name:_____

(please continue on page 2)

Medical History form page 2

Do you have, or have you had, any of the following diseases or problems?

Diabetes	☐ Yes	☐ No	Hypertension	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Allergies	☐ Yes	☐ No	Immune System	☐ Yes	☐ No
Bowell	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Circulatory	☐ Yes	☐ No	Mental Illness	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Renal Disease	☐ Yes	☐ No
Nervousness	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Respiratory	☐ Yes	☐ No
Easily Frustrated	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Loss of Spouse	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Drug Abuse	☐ Yes	☐ No	Loss of Socializing	☐ Yes	☐ No
GI Disturbances	☐ Yes	☐ No	Urinary Problems	☐ Yes	☐ No
Hearing Problems	☐ Yes	☐ No	Visual Problems	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Unsteady on feet	☐ Yes	☐ No

Please describe any "yes" answers to the above questions:_____

_____

_____

_____

Do you have any disease or problem not listed above that we should know about? Please explain…

_____

What kinds of goals or activities would you like to be able to do after completing therapy: _____

_____

_____

_____

PSYCHOSOCIAL SERVICES:

offers psychosocial services. Would you like to be seen by our Licensed Clinical Social Worker (LCSW) for an evaluation?

Yes If YES, please write reason for evaluation:_____

No If NO, please sign below:

I am aware of an LCSW on staff and psychosocial services at . At this point I do not require a psychosocial evaluation.

_____

Patient's Signature (or individual completing this form for patient)

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE. I ACKNOWLEDGE THAT MY QUESTIONS, IF ANY, ABOUT THE EVALUATION PROCESS WILL BE ANSWERD TO MY SATISFACTION. I WILL NOT HOLD THE PROGRAM OR ANY OF ITS STAFF RESPONSIBLE FOR ANY ERROR OR OMISSIONS THAT I HAVE MADE IN THE COMPLETION OF THE FORM.

_____ _____

Patient's Signature (or individual completing this form for patient) Date

Patient Name:_____

RESPIRATORY THERAPY CLINICAL OUTCOMES~~INITIAL VISIT~~

EDUCATION~~Rate yourself on how well ~ you understand the below materials~	**I DO UNDERSTAND** →				**I DON'T UNDERSTAND**
Anatomy & Physiology of Lungs	1	2	3	4	5
Benefits of Exercise	1	2	3	4	5
Controlled Cough	1	2	3	4	5
Controlling Stress	1	2	3	4	5
Depression Management	1	2	3	4	5
Diaphragmatic Breathing	1	2	3	4	5
Disease Process	1	2	3	4	5
Energy Conservation Techniques	1	2	3	4	5
Environmental Issues/Triggers causing Shortness of breath	1	2	3	4	5
Home Exercise	1	2	3	4	5
Infection Control	1	2	3	4	5
Medication Administration/effects/Side effects	1	2	3	4	5
Oxygen Therapy & Use	1	2	3	4	5
Pursed Lip Breathing	1	2	3	4	5
Relaxation Exercises	1	2	3	4	5
Secretions	1	2	3	4	5
Spirometry/PFT Results	1	2	3	4	5
Travel	1	2	3	4	5
Recovering From Severe shortness of breath	1	2	3	4	5
LEVEL OF DIFFICULTY	**Easy** →				**Hard**
Eating	1	2	3	4	5
Simple personal care (washing face, combing hair)	1	2	3	4	5
Taking full bath or shower	1	2	3	4	5
Dressing	1	2	3	4	5
Picking up or Straightening up	1	2	3	4	5
Sweeping or Vacuuming	1	2	3	4	5
Shopping	1	2	3	4	5
Cooking or doing dishes	1	2	3	4	5
Laundry	1	2	3	4	5
Walking around your house	1	2	3	4	5
Walking your pace on level surfaces	1	2	3	4	5
Walking one block	1	2	3	4	5
Walking with others your age	1	2	3	4	5
Walking up a slight hill	1	2	3	4	5
Walking up stairs	1	2	3	4	5

Patient Name: _____