REGISTRATION FORM

(Please Print)

Today's Date: _____

PATIENT INFORMATION

Last name:	First:	Middle:
Birth date:	Age:	Sex: ☐ M ☐ F
Street address:	Home/Cell phone no.:	
Zip code:	City:	State:
Email Address:		

CONTACT PREFERENCES

Altius Physical Therapy may contact you by phone call, text message, email, or mail about appointments, billing, and your care.

If you do NOT wish to be contacted by any of these methods, please list them here:

_____

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Altius Physical Therapy or insurance company to release any information required to process my claims.

Patient/Guardian signature: _____ Date: _____

MEDICAL HISTORY FORM

History of Current Problem(s)

The date your problem(s) began (month/date/year): _____

What happened?

What are your goals for therapy?

Medications

Please list all prescription and over-the-counter medications (do not include vitamins or supplements).

Medical History

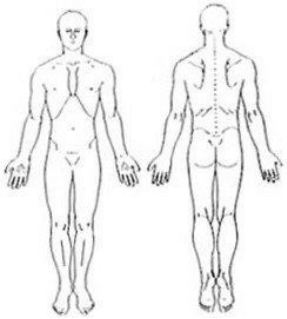
Please check if you have ever had:

☐ Developmental or growth problems	☐ Kidney problems	☐ Heart issues
☐ Circulation/vascular problems	☐ Infectious disease	☐ Arthritis
☐ Low Blood Sugar/Hypoglycemia	☐ Lung problems	☐ Allergies
☐ Alcohol/Drug dependency	☐ Muscular Dystrophy	☐ Osteoporosis
☐ Repeated infections	☐ Seizures/Epilepsy	☐ Depression
☐ Ulcers/Stomach problems	☐ Blood disorders	☐ Head injury
☐ Diabetes/high blood sugar	☐ Multiple Sclerosis	☐ Cancer
☐ High Blood Pressure	☐ Stroke	☐ Parkinson's Disease
☐ Skin Diseases	☐ Other _____	

Surgeries

Please list any surgeries including year:

Please mark on the drawings below, the areas where you feel pain.



Pain Scale: On the line below, please mark where your "pain status" is today.

No Pain Most Severe Pain

Altius Physical Therapy

Consent for Treatment

I agree and give Altius Physical Therapy permission to furnish physical therapy to myself or my dependent, which is considered necessary and proper to treat myself or my dependent's condition.

Initials: _____

Assignment of Benefits

I authorize payment of medical insurance benefits to be made directly to Altius Physical Therapy on my behalf for physical therapy services rendered. I also authorize Altius Physical Therapy to release my protected health information for treatment and billing purposes.

Initials: _____

Notice of Privacy Practices

I have received a written copy of Altius Physical Therapy's Notice of Privacy Practices. The notice provides, in detail, the uses and disclosures of my protected health information that may be available by Altius Physical Therapy, my rights as a patient, and Altius Physical Therapy's legal duties with respect to my protected health information.

Initials: _____

Financial Policy

As a courtesy, Altius Physical Therapy will pre-verify your insurance benefits. Please note, unless you have secondary insurance all co-pays, deductibles, and/or co-insurance is the patient's/guardian's (in the case of a minor) responsibility. Co-pays are due at the time services are rendered. Your deductible/co-insurance will be billed to you once we receive an 'explanation of benefits' from your insurance carrier. The responsibility for any services not paid by your health insurance is patient responsibility. Payment methods include cash, check, money order and credit card. Returned checks and balances older than 90 days are subject to additional charges.

Initials: _____

Signature on File

I have read, gained understanding of, and agree with the above policies and procedures. I authorize this signature on all insurance submissions.

Patient's/Guardian's Signature: _____ Date: _____

Altius Physical Therapy

CANCELLATION & NO-SHOW POLICY

We'd like to share a reminder about our cancellation policy.

We ask that you provide at least 24 hours' notice if you need to cancel or reschedule an appointment. We understand that life happens and always try to be flexible whenever possible. If your schedule changes, we'll do everything we can to move your appointment to a different time that day or find another time for you that same week.

When appointments are cancelled with little notice or missed, it can be difficult to offer that time to other patients who may be waiting for care.

Repeated late cancellations, cancellations with less than 24 hours' notice, or no-shows may result in a $40 fee per appointment.

If you need to make a change to your appointment, please call or leave a voicemail at 201-391-8932, or email us at office@altiusnj.com.

Thank you for your understanding and for helping us keep the schedule running smoothly!

Please read and initial each statement below:

☐ I understand and agree that repeated late cancellations, cancellations with less than 24 hours' notice, or no-shows may result in a $40 fee per appointment. **Initials:** _____

☐ I understand that I can cancel or reschedule by calling 201-391-8932 or emailing office@altiusnj.com. **Initials:** _____

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