

Winebrenner & Associates'



**Charter Physical Therapy, LLC<sup>®</sup>**  
*Setting Your Course for Recovery and Wellness*

### Patient Registration Form

Last name \_\_\_\_\_ First name \_\_\_\_\_ M \_\_\_\_\_

Date of birth \_\_\_\_\_ Social Security Number \_\_\_\_\_ Sex:  M  F

Street Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Emergency contact \_\_\_\_\_ Phone number \_\_\_\_\_

Referring physician \_\_\_\_\_ Phone number \_\_\_\_\_

Primary care physician \_\_\_\_\_ Phone number \_\_\_\_\_

Reason for referral \_\_\_\_\_

Please check if the condition you are seeking treatment for is related to a:

Auto Accident  Workman's Comp Claim  Personal Injury Claim Date of injury: \_\_\_\_\_

#### Health Insurance Information

Primary Insurance \_\_\_\_\_ Address \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Policy holder \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Address \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Policy holder \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

I authorize the release of any medical information necessary to process this claim. I also request payment of benefits directly to Charter Physical Therapy, LLC. I am responsible for the payment balance not covered by my insurance. Any appointment not canceled within 24 prior to scheduled time may be subject to a charge. Patients who miss or cancel 2 appointments without 24 hours notice will receive additional appointment at the discretion of the Physical Therapist.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Medical Information

Are you diabetic?                     Yes    No

Do you have any artificial joints?     Yes    No

Are you taking insulin?             Yes    No

Do you have any artificial limbs?     Yes    No

Have you ever had cancer?         Yes    No  
Type \_\_\_\_\_ When \_\_\_\_\_

Do you have any cardiac problems?    Yes    No

Are you or could you be pregnant?    Yes    No

Do you have any allergies?         Yes    No  
Type:      Seasonal      Medication  
Please list \_\_\_\_\_

Do you have difficulty hearing?       Yes    No

Wear hearing aides?                   Yes    No

Do you have other health problems?    Yes    No  
Please list \_\_\_\_\_

Hospitalizations/ Surgeries (past 2 years) \_\_\_\_\_

Current Medications \_\_\_\_\_

Have you received physical therapy before?     At Charter PT     At another facility     No

If yes: When \_\_\_\_\_ For what body part \_\_\_\_\_

Any other information about your health that your therapist should know: \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Medicare Patients:

Under the Balanced Budget Act of 1997, Congress placed financial limitations on outpatient physical therapy services commonly referred to as caps. The current amount is \$1870 per calendar year. You will be financially liable for services provided above the cap. To assist you, we track your charges and notify you when you are approaching the allowed amount. It is your obligation to inform us of any prior physical therapy or speech therapy services received during the current calendar year to allow us to determine the amount already used. For further information, please contact your local Medicare office.

Have you received physical or speech therapy previously this calendar year?     Yes             No

Signature \_\_\_\_\_ Date \_\_\_\_\_