



Patient Registration

First _____ MI _____ Last Name _____		Date of Birth _____												
Address _____		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female												
City _____	State _____	Zip _____												
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Telephone Numbers</th> <th style="width: 10%;">OK To Call</th> <th style="width: 60%;">Best Time To Call</th> </tr> </thead> <tbody> <tr> <td>Home _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Work _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Cell _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td>_____</td> </tr> </tbody> </table>		Telephone Numbers	OK To Call	Best Time To Call	Home _____	<input type="checkbox"/>	_____	Work _____	<input type="checkbox"/>	_____	Cell _____	<input type="checkbox"/>	_____	Marital Status <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Unknown Employment Status <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Self Employed <input type="checkbox"/> Active Military <input type="checkbox"/> Retired <input type="checkbox"/> None
Telephone Numbers	OK To Call	Best Time To Call												
Home _____	<input type="checkbox"/>	_____												
Work _____	<input type="checkbox"/>	_____												
Cell _____	<input type="checkbox"/>	_____												
Email Address _____														
Social Security # _____		Student Status <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> None												
Driver's Lic # _____ Issuing State _____														
Patient's Employer _____ Address _____ Phone _____ Occupation _____		<i>We are dedicated to improve the quality of every life we touch...</i>												
Spouse's Name _____ Employer _____ Address _____ Phone _____ Occupation _____														
		Emergency Contact _____ Address _____ Phone _____ Relation _____												
		Family Physician _____												
Primary Insurance _____ Address _____		Phone _____ Effective Date _____ ID # _____ Group # _____												
If Auto Insurance, Name of Insured _____														
Subscriber's Name _____		Patient's Relation to Subscriber _____												
Social Security # _____		Date of Birth _____ Gender <input type="checkbox"/> Male <input type="checkbox"/> Female												



Secondary Insurance _____ Phone _____
 Address _____ Effective Date _____
 _____ ID # _____
 If Auto Insurance, Name of Insured _____ Group # _____
 Subscriber's Name _____ Patient's Relation to Subscriber _____
 Social Security # _____ Date of Birth _____ Gender Male Female

Was this injury/accident related to: Sports Work Automobile School Other _____
 Name of School or Employer at the time of Injury _____ Date of Injury _____

Attorney's Name (if applicable) _____ Phone _____

How did you hear about us?
 Physician Hospital Marketing Ad - Print
 Employer Cross Referral Marketing Ad - TV
 Case Manager Friend - Word of Mouth Marketing Ad - Billboard
 Former Patient Attorney Marketing Ad - Direct Mail - Email
 Adjustor Self Marketing Ad - Theater
 School Screens - Open Houses
 Other, Please specify: _____

I authorize insurance benefits to be paid directly to PT PROS Physical Therapy and Sports Centers (PT PROS) and also authorize release of any or all medical records to my insurance company and its agents including rehabilitation coordinators. Further, I authorize PT PROS to obtain needed information from my physician, employer or insurance company. By signing below, I am also authorizing PT PROS to treat the above referenced patient and verify that I am said patient or the parent or legal guardian thereof.

NOTICE: By signing this agreement I acknowledge and understand that an interest charge of 1.5% per month will automatically be added to any unpaid balance each month. Furthermore, I understand and agree that if PT PROS is forced to take legal action to collect any part of my account which remains unpaid, I agree that I am responsible for any and all legal fees, including but not limited to attorney fees, which PT PROS incurs as a result of collecting such an account. I understand that I am responsible for any remaining balance owed to PT PROS.

X _____ Date _____

Patient Signature (Parent or Guardian if minor)
We at PT Pros realize that you have a choice with your physical therapy care and appreciate the opportunity to meet any expectations of care you may have. If at any time, you have questions, concerns, or suggestions please contact our Director of Patient Care at (606) 526-2210.



Medical History

UNDEF

Area of Symptoms: _____

Date of Onset: _____ Age: _____

Please take a moment to complete the questions below. Depending on your answers, we may modify our treatment procedures for their effectiveness and your safety. Thank you.

Any known results of recent x-rays or tests: _____

Chronic Conditions: Yes No If yes, please list: _____

Allergies: Seasonal? Latex? Please list: _____

List surgeries and dates: _____

Medications: Yes No If yes, please list: _____

Have you ever had treatment for this injury before? Yes No If yes, please specify: _____

How do you sleep at night? Please check all that apply:

Difficulty falling asleep Difficulty finding a comfortable position Awaken by pain

Other, please specify: _____

Do you have or have you had any of the following:

- | | | | |
|----------------------|----------------------------------------------------------|----------------------|----------------------------------------------------------|
| Cancer | Yes <input type="checkbox"/> No <input type="checkbox"/> | High Blood Pressure | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Diabetes | Yes <input type="checkbox"/> No <input type="checkbox"/> | Metal Implants | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Epilepsy or Seizures | Yes <input type="checkbox"/> No <input type="checkbox"/> | Respiratory Problems | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Heart Disease | Yes <input type="checkbox"/> No <input type="checkbox"/> | Arthritis | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Pacemaker | Yes <input type="checkbox"/> No <input type="checkbox"/> | Are you pregnant? | Yes <input type="checkbox"/> No <input type="checkbox"/> |

In the past 3 months, have you had or do you experience:

- | | | | |
|---------------------------|----------------------------------------------------------|--------------------------------------|----------------------------------------------------------|
| A change in your health | Yes <input type="checkbox"/> No <input type="checkbox"/> | Changes in bowel or bladder function | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Nausea/Vomiting | Yes <input type="checkbox"/> No <input type="checkbox"/> | Shortness of breath | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Fever/Chills/Sweats | Yes <input type="checkbox"/> No <input type="checkbox"/> | Dizziness | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Unexplained weight change | Yes <input type="checkbox"/> No <input type="checkbox"/> | Upper Respiratory Infection | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Numbness or tingling | Yes <input type="checkbox"/> No <input type="checkbox"/> | Urinary Tract Infection | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Changes in appetite | Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| Difficulty swallowing | Yes <input type="checkbox"/> No <input type="checkbox"/> | | |



Personal Representative Authorization

Member Name: _____

Section A - Purpose

This form allows you (the "Individual") to give PT PROS, Inc. permission (authorization) to disclose your protected health information (PHI) to a person that will act as your Personal Representative. The information covered by this authorization is protected health information, including identification of treating providers of care; diagnoses; procedures; and personal information, such as your date of birth and mailing address. Each adult family member, including each adult child (age 18 or older, or as determined by state law), who wishes to name a Personal Representative must complete an authorization form. For example, if you expect your spouse to call us on your behalf, you need to fill out this form. If you do not wish to name a Personal Representative, do not complete this form. You are not required to name a Personal Representative, but if you do not, we will not release your protected health information to someone who may call or write on your behalf. Your Personal Representative maybe anyone of your choosing, such as a spouse, parent, child, friend, congressman or Union representative. You must provide the information requested in Section C for each person before we can treat that person as your Personal Representative. If you need additional forms, you may copy this form, or call us. Please note: This authorization does not give your Personal Representative authority, either implied or direct, over any treatment of direct care decisions. Also, we will not condition enrollment, eligibility for benefits, or benefits payments on your completion of this form.

Section B - Individual's Information

I authorize PT PROS, Inc. to treat the person(s) named in Section C as my Personal Representative(s), subject to the rights and restrictions, if any, described in Section C.

My Name	Date of Birth	Daytime Phone	Relationship to Member
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Section C - Authorized Usa and/or Disclosure

I understand that the PT PROS, Inc.'s privacy practice is to not disclose my personal health information, except for the purpose of treatment, payment, and health care operations, or as required by law, without my written authorization. For this reason, I authorize you to disclose my protected health information to the person(s) named in Section C for the purpose of assisting with or facilitating the payment of my health plan benefits. Unless I have stated otherwise in Restrictions, I also allow my Personal Representative for the following rights: the right to request amendment of my PHI; the right to request an accounting of disclosures of my PHI; and the right to request restrictions on disclosure of my PHI. I understand that if my Personal Representative is not a health plan, a health care provider or another entity subject to federal or applicable state privacy laws, those laws may no longer protect my personal health information, and my Personal Representative may further disclose my protected health information without my authorization. I acknowledge that my authorization is voluntary. I understand that I have the right to limit the information you release under this authorization. For example, I may limit a Personal Representative's access to information only about a particular provider or diagnosis/disease; or I may allow a Personal Representative access to everything except information from a particular provider or about a particular diagnosis/disease. Any such limitations must be described in Restrictions, in this section.

Personal Representative #1

<i>Full Name (please print)</i>	<i>Phone Number</i>	<i>Relationship to You (such as: spouse, parent, child, friend)</i>	<i>Restrictions</i>
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Personal Representative #2

<i>Full Name (please print)</i>	<i>Phone Number</i>	<i>Relationship to You (such as: spouse, parent, child, friend)</i>	<i>Restrictions</i>
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Section D - Revocation

I understand that I have the right to revoke or end this authorization at any time. I understand that, if I do not wish any person named in Section C to remain my Personal Representative, I must revoke my authorization by giving written notice of my decision to the Privacy Official at the address shown below. I understand that my revocation of this authorization will not affect any action that you have taken or information that you have already released, based upon the authorization, before you receive my request to revoke authorization.

PT Pros, Inc. 383 Corbin Center Drive Corbin, KY 40702

Section E - Signature/Authorization

I, _____, have had full opportunity to read and consider the content of this form. I understand that by signing this form, I am confirming my authorization that PT PROS, Inc. may disclose my protected health information to the person(s) named on this form, for the purpose described above.

Signature: _____ Date: _____

Please complete and sign this form, and return it to our Office Manager. You are entitled to a copy of this completed form.



Summary of our Notice of Privacy Practices

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, acknowledge that I have received the Notice of Privacy Practices from PT Pros, Inc.

X _____ Date _____
Patient Signature (Parent or guardian if minor)

In lieu of a patient signature, I, _____, a staff member of PT Pros, Inc., state that _____ has been given our current Notice of Private Practices.

X _____ Date _____
Staff member of PT Pros, Inc.