MAPLE LEAF PHYSICAL THERAPY PATIENT REGISTRATION FORM

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This information is important. Please fill in every box. If information does not apply, please put X in box.			
Today's Date:	Date of Birth:	Social Security#	
Name:	Street Address		
City	State	Zip	
Home Phone	Mobile	Email	
Emergency Contact	Phone		
Employer	Occupation		
Employer Address:	City/State:	Zip:	
Insurance Carrier:	Subscriber (If Other Than Patient)::		
Insurance ID #:			
Secondary Insurance:	Insurance ID #		
Referring Physician:			
Reason for Physical Therapy:			
Is your injury work related?	Yes	No	
Is your injury due to a motor vehicle accident?	Yes	No	
If the answer is yes to work related or motor vehicle injury, please provide the following information:			
Date of injury:	Claim Number:		
Name of Claim Adjuster:	Phone:		
Insurance Company			
Have you retained an attorney?	Yes	No	
Name of Claim Attorney:	Phone:		
Attorney Address:	City/State:	Zip:	

Billing Policies:

As a courtesy, we will verify all insurance benefits. All deductibles, coinsurance, and/or co-pays are the patient's responsibility co-pays are due at the time of service: deductibles and coinsurance will be billed to you once an **Explanation of Benefits (EOB)** has been generated by your insurance carrier.

For your convenience, we accept cash, checks, money orders, and all major credit cards. Delinquent accounts are subject to collection fees and interest at a rate of 5% per month. Returned checks are subject to a $35 fee. If you require assistance with billing matters, please feel free to contact our office at any time.

At your request your credit card information may be securely scanned into an encrypted file and account balances may be charged once per week or biweekly at your discretion. Payment on file, does not compromise your right to dispute patient balances or to obtain itemized statement/receipts.

Please be advised, our office requires a **24 hour notice if you need to cancel** an appointment. We are sensitive to the needs of our patients and understand emergencies arise; however, in order to maximize the benefits of physical therapy it is highly recommended that patients make every effort to attend their schedule appointments. Constant ***No-Show*** patients will be subjected to a $25 cancellation fee.

I have read the above policies. I authorize Maple Leaf Physical Therapy to bill my insurance carrier for services rendered on my behalf. I authorize my insurance carrier to assign benefits directly to Maple Leaf Physical Therapy. I also authorize Maple Leaf Physical Therapy to release medical records for treatment and billing purposes.

Print Name_____

Signature_____

Maple Leaf Physical Therapy Medical History Form

Social History

Occupation		**#Years**	
Have you ever been a smoker?		Yes	No
If so:	# Years?	# Packs per day?	
Have you ever cigars or a pipe?		Yes	No
Do you drink alcohol?	Never	Occasional	Frequent

Do you have any allergies?	Yes	No	List:

Please list any medications you are currently taking (prescription or over the counter):

Do you have a history of any of the following? (Please circle yes or no)

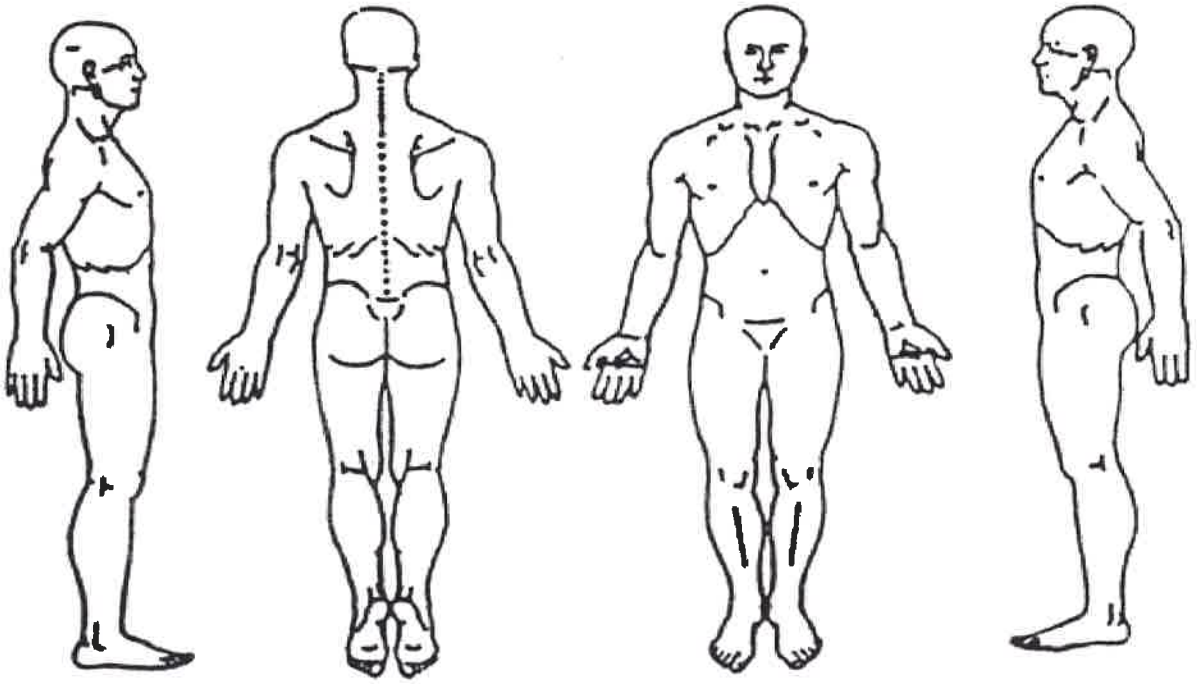
Anemia	y	n	Diabetes/High Blood Sugar	y	n	Emphysema/Bronchitis	y	n
Cancer/Leukemia/Lymphoma	y	n	Thyroid Disease	y	n	Ulcers	y	n
Easy Bleeding or Bruising	y	n	Stroke	y	n	Hepatitis	y	n
Colon Polyps	y	n	Seizures/Convulsions/Epilepsy	y	n	Kidney Disease	y	n
Heart Attack/Angina	y	n	Tuberculosis	y	n	Venereal Disease	y	n
Rheumatic Fever	y	n	Pneumonia	y	n	Arthritis	y	n
Heart Murmur	y	n	Asthma	y	n	Systemic Lupus Erythematosus	y	n
Palpitations/Irregular Heartbeat	y	n	Hay fever	y	n	Scleroderma	y	n
Congestive Heart Failure	y	n	Sinus Problems	y	n	HIV	y	n

Do you experience any of the following symptoms? (Please circle yes or no)

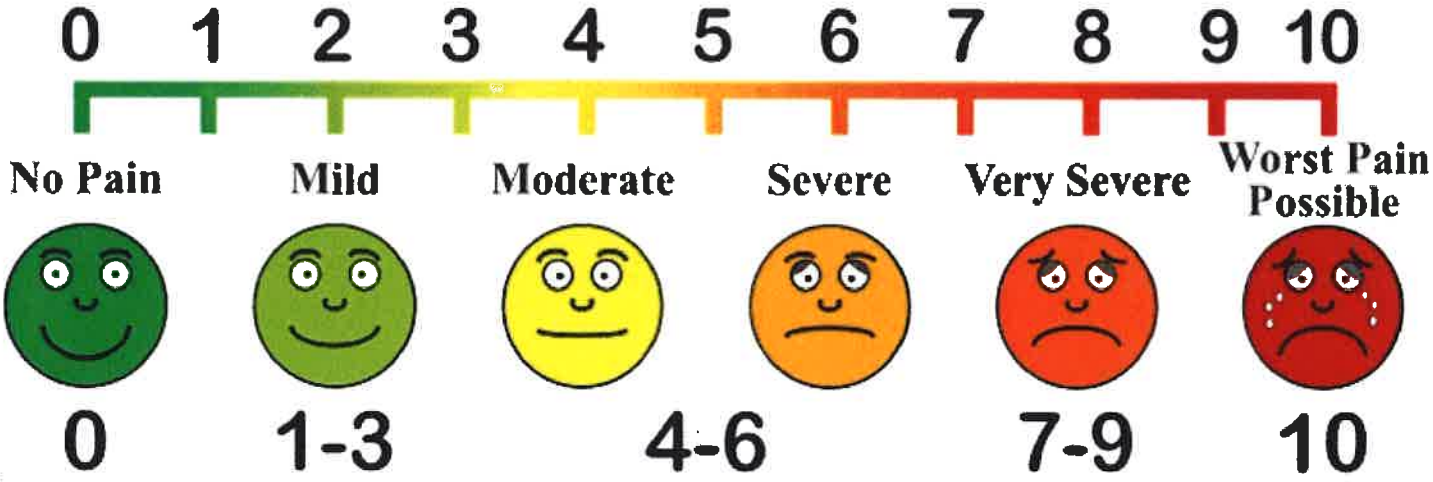
Fever, Chills, Sweats	y	n	Loss of Appetite/Weight Loss	y	n	Fatigue	y	n
Swollen Glands/Lumps	y	n	Bruising/Bleeding	y	n	Headache	y	n
Numbness/Tingling	y	n	Speech/Memory Change	y	n	Loss of Balance/ Dizziness	y	n
Weakness	y	n	Change of Vision	y	n	Stiff Neck	y	n
Chest Pain	y	n	Wheezing/Shortness of Breath	y	n	Painful Breathing	y	n
Chronic Cough	y	n	Nausea/Vomiting	y	n	Abdominal Pain	y	n
Muscle Ache/Pain	y	n	Joint Pain/Aching Bones	y	n	Falls within the last year	y	n

Maple Leaf Physical Therapy Pain Locator and Intensity Chart

1. Indicate where your pain is on the body chart below
2. Describe whether your pain is Achy, Burning, Numb, Pins & Needles (PN), Stabbing



Please indicate your level of pain. Please use the numbers and the illustrations to help you determine your current level of pain. If there are special circumstances regarding your pain pattern please note on the diagram. For instance if you had a steroid shot two days ago, indicate your pain level after the shot. Please note your pain prior to the shot by circling the appropriate number and putting a date on it.



Please Let Us Know How You Heard About Us

- ❑ Word of Mouth Referral
- ❑ Been Here Before (Repeat Attendance)
- ❑ Physician Suggestion
- ❑ A Friend's Recommendation
- ❑ Supermarket Shopping Cart
- ❑ MLPT Website
- ❑ Search Engine (Gooogle, Bing, Yahoo etc)
- ❑ Facebook
- ❑ Twitter
- ❑ Pinterest
- ❑ Yelp
- ❑ Newspaper Ad
- ❑ Other_____

MAPLE LEAF PHYSICAL THERAPY

PO Box 663 • 255 Messina Avenue • Hammonton, NJ 08037

An Independently Owned Practice of Physical Therapy

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RELEASE FORM

It is our pleasure to provide you with your physical therapy, We feel our clinic is unique in that it is privately owned and not an affiliate or subsidiary of a large hospital chain or medical practice. To help us continue to provide service at this level we ask you to assist us with our marketing program. Our MLPT website as well as written brochures helps us to communicate our service in this highly competitive market. Please understand that we very much appreciate your cooperation in this matter but fully understand if you choose not to participate.

By signing this release form, I authorize [Maple Leaf Physical Therapy], to use the following information:

(1) My picture – including photographic, motion picture, and electronic (video) images.
(2) My voice – including sound and video recordings.

I hereby grant to [Maple Leaf Physical Therapy], its subsidiaries, licensees, successors and assigns, the right to use, publish, and reproduce, for all purposes, my name, pictures of me in film or electronic (video) form, sound and video recordings of my voice, and printed and electronic copy of the information described in sections (1) and (2) above in any and all media including, without limitation, cable and broadcast television and the Internet, and for exhibition, distribution, promotion, advertising, sale, press conferences, meetings, hearings, educational conferences and in brochures and other print media. This permission extends to all languages, media, formats and markets now known or hereafter devised. This permission shall continue forever unless I revoke the permission in writing.

I further grant [Maple Leaf Physical Therapy] all rights, title, and interest that I may have in all finished pictures, negatives, reproductions, and copies of the original print, and further grant [Maple Leaf Physical Therapy] the right to exhibit the print in copies or facsimiles thereof, for marketing, communications, or advertising purposes, as it deems fit.

I hereby waive the right to receive any payment for signing this release and waive the right to receive any payment for [Maple Leaf Physical Therapy's] use of any of the material described above for any of the purposes authorized by this release. I also waive any right to inspect or approve finished photographs, audio, video, multimedia, or advertising recordings and copy or printed matter or computer generated scanned image and other electronic media that may be used in conjunction therewith or to approve the eventual use that it might be applied.

I acknowledge that I have read the foregoing and I fully understand the contents.

Print Name: Telephone Number:

Address: Signature:

City/State/Zip: Date:_____