Summit Physical Therapy & Rehab
PATIENT REGISTRATION

DATE: _____
REFERRING PHYSICIAN: _____
LAST NAME: _____ FIRST NAME: _____ MI: _____
PHYSICAL ADDRESS: _____
CITY_____ STATE _____ ZIP _____
E-MAIL ADDRESS: _____
MAILING ADDRESS: _____
CITY _____ STATE _____ ZIP _____
HOME # _____ CELL # _____ WORK # _____
DATE OF BIRTH: _____ SSN: _____
INSURANCE WE WILL BE BILLING: _____
EMPLOYERS NAME: _____
EMPLOYERS ADDRESS: _____
SPOUSES'S NAME/EMERGENCY CONTACT: _____
EMERGENCY CONTACT NUMBER: _____
SPOUSES'S EMPLOYER: _____
Phone # for appt reminder messages: _____ __Text __Voice

Below is an explanation of your benefits as provided by your insurance company. This is not a guarantee of your benefits as it is your responsibility to obtain your exact information. By signing below you are stating that you understand your benefits. **Any amounts not covered by your insurance will be billed to you upon completion of treatment.**

PLEASE INITIAL _____

DEDUCTIBLE: _____ AMOUNT MET: _____
CO-PAY: _____ COPAYS ARE DUE AT TIME OF SERVICE
CO-INSURANCE: _____
OUT-OF-POCKET MAXIMUM: _____ AMOUNT MET: _____
LIMITATIONS ON THERAPY SERVICES: _____
_____
_____

PATIENT RELEASE

I HEREBY AUTHORIZE SUMMIT PHYSICAL THERAPY & REHAB AND ITS AGENTS TO FURNISH ALL INFORMATION IT MAY HAVE REGARDING MY CONDITION, TREATMENT AND PROGRESS WHILE UNDER SUMMIT PHYSICAL THERAPY & REHAB'S OBSERVATION OR TREATMENT (INCLUDING THE HISTORY OBTAINED, PHYSICAL FINDINGS, AND PROGNOSIS) TO THE INSURANCE COMPANY OR ITS REPRESENTATIVES, MY EMPLOYER, MY PHYSICIAN, OR MY ATTORNEY UPON THEIR REQUEST OR DURING TREATMENT AND PROGRESS CONFERENCES. THIS AUTHORIZATION SHALL REMAIN VALID UNTIL REVOKED BY ME IN WRITING. ADDITIONALLY, I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO SUMMIT PHYSICAL THERAPY & REHAB FOR SERVICES RENDERED, AND FULLY ACCEPT TOTAL RESPONSIBILITY FOR ALL SERVICES NOT FULLY PAID FOR BY ANY INSURANCE COMPANY, AND/OR MEDICARE/MEDICAID.

PATIENT SIGNATURE _____ DATE _____
PARENT/GUARDING SIGNATURE: _____ DATE _____

NOTICE OF PRIVACY PRACTICES
Summit Physical Therapy and Rehab, Inc.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Summit Physical therapy is required by law to protect certain aspects of your health care information known as Protected Health Information or PHI and to provide you with this Notice of Privacy Practices.

Uses and Disclosures of PHI: Summit Physical Therapy may use PHI for the following purposes:

1. For Treatment: summit may use and disclose your PHI to doctors, nurses, technicians, or healthcare professionals caring for you.
2. For Payment: summit may use and disclose your PHI to obtain reimbursement and determine eligibility.
3. For Healthcare Operations: Summit may use and disclose your PHI for operations such as employee evaluations, licensing, credentialing, and compliance activities.
4. For Emergency Notification: Summit may use and disclose your PHI to a family member or another person responsible for your care in the event of an emergency.
5. For Law Enforcement Purposes: Summit may use and disclose your PHI if we suspect you are a victim of abuse, neglect, or domestic violence. We may also use and disclose your PHI for national security, criminal and/or intelligence activities.
6. For Court Orders and Judicial Matters: Summit may use and disclose your PHI in response to subpoena, discover requires, court or administrative order, or other legal request.
7. For Public Health Purposes: Summit may use and disclose your PHI to public health authorities involved in the prevention or control of disease, injury, or disability.
8. For Workers Compensation: Summit may use and disclose your PHI in compliance with workers compensation laws.
9. For Health Oversight Purposes: Summit may use and disclose your PHI to entities providing health oversight, including audits, licensure or disciplinary actions, inspections and other authorized activities.

Any other use or disclosure of PHI, other than those listed above will only be made with your written authorization. You may revoke your authorization at any time, in writing, except to the extent that we have already used or disclosed medical information based pon that authorization.

Patient Rights:

1. You have the right to access, copy or inspect your PHI. Summit will normally provide you with access to your PHI within 30 days of the request and we have the right to charge for copies made.
2. You have the right to amend your PHI. If errors are found we have 60 days to amend the PHI. Summit is permitted to deny your request to amend in certain circumstances.
3. You have the right to request an accounting of Summit's use and disclosure of your PHI. Summit is not required to give an account for uses and disclosures involving treatment, payment, when sharing your PHI with our staff, or for PHI which we have been given written authorization for.
4. You have the right to request additional restrictions or disclosures of your PHI. However, restrictions or disclosures will not be honored if emergency treatment is needed.

Questions or Complaints:

If you have any questions or complaints regarding this notice, Summit has a designated "Privacy Officer" whom you may contact. Simply ask to speak with Summit's "Privacy Officer", or address written correspondence to Summit Physical therapy, Attn: Privacy Officer, 1071 W. Blue Starr Drive, Claremore, OK 74017. You may contact us at 918-342-3800. If you file a complaint against us, we will not retaliate in any way.

Patient Acknowledgement:

I have received Summit Physical Therapy & Rehab's Notice of Privacy Practices, and I have been given the opportunity to review it.

Patient Name (please print): _____ Date: _____

Signature: _____

SUMMIT
Physical Therapy & Rehab
Physical, Occupational & Speech Therapy Specialists
Claremore - 342-3800 • www.ptsummit.com

MEDICAL HISTORY FORM

In order to better serve your needs we ask that you fill out this form as complete as possible. Please feel free to skip any question that you do not understand or does not apply.

Name:_____ **Age:**_____ **Date:**_____

PAST MEDICAL HISTORY

Please check the line next to any condition you currently have or have had in the past

___ AIDS/HIV	____ Anemia	___Angina	____Unexplained Weight Loss
___ Asthma	____ Back Problems	___Bleeding Disorders	____Arthritis
___ Hepatitis or Jaundice	____ Diabetes	___ Low Blood Pressure	____ High Blood Pressure
___ Ear Problems	___ Epilepsy	___ Headaches	____ Heart Disease
___ Foot/Leg Cramps	____Muscular Disease	___Osteoporosis	____ Pregnancy
___ Cancer	___ Ulcers	___Phlebitis	____Psychiatric Care
___ Sinus Problems	____Stroke	___Swelling	____Shortness of Breath
___ Respiratory Disease	____ Tuberculosis	___Pacemaker	____Heart Attack
___ Emphysema	____Broken Bones	___Fibromyalgia	____Loss of Balance
___ Dizziness	____Night Sweats		

Other:_____

SURGERIES

Please list any previous major surgeries:

_____

_____

_____

MEDICATIONS

Prescriptive medications: (Medicare patients use separate form)

Please check the class of prescription drugs you are taking:

___ Pain Medication	____ Muscle Relaxers	____ Anti-inflammatories	____Cardiac
___ Allergy	____ Blood Thinner	____ Diuretic	____Calcium
___Insulin	Other:_____		

Please check any over-the-counter medications you are taking:

___ Anti-inflammatories	___ Tylenol/Acetominophen	___ Antacids	___Laxatives
___ Antihistimines	___ Decongestants/Anithistimine	___ Aspirin	___Herbals/Vitamins

___ Other:_____

ALLERGIES

___ Latex ___ Iodine ___ Dexamethasone ___ Tape Adhesive ___Bromine/Chlorine

Other: _____

Do you: ___ Smoke: If yes, how many packs a day (circle): ½ 1 2 more

CURRENT HISTORY

Describe your symptoms: _____

_____

Date of onset: _____ Date of Surgery (if applicable): _____

Since the onset have your symptoms: ____ worsened ____ improved ____ stayed the same

What makes your pain worse:

___sitting ___walking ___twisting ___bending ___squatting ___stairs ___push/pull

___standing ___kneeling ___reaching ___lifting ___rising from chair ___cough/sneeze

___riding in a car Other: _____

What makes your pain better:

___heat ___ice ___rest ___medications ___change in position ___exercise

Other: _____

Describe your pain: ___sharp ___dull ___aching ___burning ___radiating ___knifelike Other: _____

Frequency of Pain: ___constant ___frequent ___infrequent ___I have no pain

Does your pain wake you up at night: Yes / No

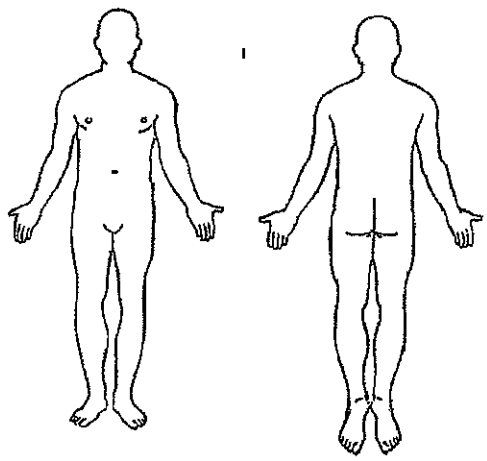
Do you have any:

Numbness: Yes / No Where: _____

Tingling: Yes / No Where: _____

Weakness: Yes / No Where: _____

PAIN RATING/LOCATION



Please mark your area(s) of pain.

What is your current pain rating

None					Moderate					Severe
0	1	2	3	4	5	6	7	8	9	10

What is your pain rating at it's worst

None					Moderate					Severe
0	1	2	3	4	5	6	7	8	9	10

What is your pain rating at it's best

None					Moderate					Severe
0	1	2	3	4	5	6	7	8	9	10

WORK/HOME ENVIRONMENT

Do you consider yourself: ___active ___moderately active ___inactive

Do you work: Yes / No Where: _____ How Long: _____

If you are not working due to your injury, when was your last day at work _____

Do you plan to return to your prior level of work: Yes / No When: _____

Does your work require: ___Heavy manual labor ___Moderate manual labor ___Light manual labor

___Primarily desk-type ___Variable but not stressful positions

What recreational activities do you like to perform: _____

_____

Are you: ___Right Handed ___Left Handed

GOALS AND OTHER

What are your goals for treatment success: _____

_____

Is there anything else we need to know prior to initiating treatment: _____

_____