Training Room Physical Therapy & Fitness Inc.
900 Glades Road Suite 1E Boca Raton, FL 33431
Tel (561)826-0334 Fax (561)826-0376

Patient Registration Form

Patient Information: Today's Date:________________________

Name:____ Gender: M / F Email:______________________

Mailing Address: ___________________________________City:________________State:________Zip:_________

Home Phone #:__________________________Cell #:____________________Work #:______________________

Date of Birth: __________________________Social Sec #:______________________Marital Status:____________

Emergency Contact:_______________________________________ Phone #________________________________

Employer:__________________________Address:__________________________Phone:___________________

Is your visit the result of a work related injury? Yes No Auto Accident? Yes No

If you answered Yes to the above questions please complete the correct section in relation to your accident.

Work Related Injury: Date of Accident:_________________________ Surgery Date:_____________________

Case Manager:________________________________ W/C Carrier:_______________________________________

Phone Number:_______________________________ Fax Number:_______________________________________

Claim or ID #:________________________________ Name of Employer:___________________________________

Auto Related Injury: Date of Accident:________________________ Auto Ins.:__________________________

Accident Claim #: __________________________________ Adjuster Name:_________________________________

Claims Address (back of card)____

Do you have an attorney? If yes – Please give us their name, address & phone number:________________________

____

Insurance/Medicare Information;

Have you received any Home Health Therapy in the last 6 months? Yes No

If Yes.. Please give us the name / phone number of the agency:____

Primary Insurance Company:__________________________ ID #:_______________________ Grp #___________

Primary Ins. Address:(see back of card)____

Secondary Insurance Co: ______________________________ ID #________________________ Grp ___________

Secondary Ins. Address: ____

Medical Information

Date of Injury / onset of symptoms :_____________________________________Surgery Date:_________________

Referring Physician:_______________________________ Phone #:____

Primary Care Physician:______________________________ Phone #:______________________________________

I clearly understand and agree that all services rendered to me are charged directly to me & that I am personally responsible for payment. Training Rm Physical Therapy & Fitness will prepare any necessary reports & forms to assist in collecting from my insurance company(s). I authorize any payments made by my insurance carriers be paid directly to the Training Rm Physical Therapy & Fitness, I understand that if I terminate my care/treatment, any fees for professional services rendered to me will be immediately due & payable, including any and all copays or additional insurance costs.

Patient / Guardian
Signature:____ Date:________________________________

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Medical History Form

Patient Name:____ Date: ______________________

Are you currently working? Yes No If No, last day worked:__________________

Is this a new condition or re-occurring? _______________ When? _____________________

Check all those that apply to your current condition:

_____Work Related Injury

_____ Injury Recurrence

_____ Aggravation of Previous Injury

_____ Fall

______ Motor Vehicle Accident

______Sports Injury

______ Lifting Injury

______ Unknown / Other:________________________

Do you have, or have you had any of the following?

	Yes	**No**		**Yes**	**No**
Diabetes	____	____	Allergies to Heat	____	____
Falls in Last Yr	____	____	Allergies to Cold	____	____
Heart Disease	____	____	Seizures	____	____
Pacemaker	____	____	Metal Implants	____	____
Headaches	____	____	Dizziness	____	____
Kidney Problems	____	____	Fractures	____	____
Pregnant, Now	____	____	Skin Allergies	____	____
Cancer	____	____	Nausea / Vomiting	____	____
Asthma	____	____	Ear Ringing	____	____
Arthritis	____	____	Hypoglycemia	____	____
Aids / HIV	____	____	Bladder Problems	____	____

If you answered Yes to any of the above, please explain & give an approximate date of occurrence:
____
____

Please Circle the test that you had preformed: X-Rays MRI CT Scan
Other:___________________________________

Are you experiencing any current health issues not listed above?
If yes, please explain:____

Are you presently taking any medication? Yes_____ No_______ If yes, what medications and dosage?
____
____

Patient Signature:____

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INFORMED CONSTENT FOR PHYSICAL THERAPY TREATMENTS AND CARE

I hereby, request and consent to the performance of Physical Therapy and other therapy procedures, including various modes of Physical Therapy Modalities and Manual Therapy, on me (or the patient named below, for whom I am legally responsible) by the Therapist named below and / or other licensed Physical Therapists and / or Physical Therapy Assistants who now or in the future treat me while they are employed by, working or associated with or serving as back-up for the Physical Therapist named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the Physical Therapist named below and / or with other offices or clinic personnel the nature purpose of therapy and other procedures.

I understand and am informed that, as in the practices of medicine, in the practice of therapy there are some risks to treatment including, but not limited to, fractures, disk injuries, strokes, dislocations and sprains. I do not expect the therapist to be able to anticipate and explain all risks and complications, and I wish to rely on the therapist to exercise judgment during the course of the procedure which the therapist feels at the times, based upon the facts then known, and is in my best interest.

I have read or have had read to me the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

TO BE COMPLETED BY PATIENT

Patients Name ________________________________ Signature of Patient ___________________________

Date Signed _______________________________ Witness of patient's signature _______________________

TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

Patient's Name ______________________________ Signature of Patient ____________________________

Date Signed_____________________ Signature of Representative_____________________________________

Relationship pr authority of Patients Representative____

Translated by____ Date ___________________________

TO BE COMPLETED BY THERAPIST OR STAFF

Name of Clinic or Office: Training Rm Physical Therapy & Fitness Inc.

Address: 900 Glades Road Suite 1E Boca Raton FL 33431

Name of Therapist(s) Treating this Patient:

1. Elvis Ramnarace, PT License # PT23540

2. Liza Tirado, PTA License # PTA22997

3.____Pin # _______________________________

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Financial Policy / Assignment of Benefits

Thank you for choosing Training Rm Physical Therapy & Fitness, Inc. as your rehabilitation provider. We will work closely with you and your physician to provide you with successful treatment. Please understand that timely payment for your treatment is important. Your clear understanding of our financial policy is important to our professional relationship. Our financial is as stated:

- All co-pays& deductibles are due at the time of service.
- Payments of patient balances are due in full at the time of service unless other arrangements have been made. If you cannot make full payment at the time of service, please discuss with our Front Office Coordinator.
- We accept cash, checks, Visa, Mastercard, Amex and Discover. There is a $35 return check fee.
- If any portion of your account balance exceeds 60 days you may be responsible for the amount regardless of your insurance.

POWER OF ATTORNEY & MEDICAL RELEASE

THE POWER OF ATTORNEY IS ONLY TO ALLOW US TO ENDORSE AND / OR SIGN ANY PAPER WHICH WILL ENHANCE OR EXPIDITE PAYMENT TO THE PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS OR AUTHORIZATION FOR YOUR INSURANCE / ATTORNEY PAY FOR YOUR SERVICES.

Known by all these present that: The undersigned has made, constituted & appointed, and by these present does hereby make, constitute and appoint Training Rm Physical Therapy & Fitness, Inc. and any of its duty authorized agents and employees as to be the undersigned's true & lawful attorney for & in the undersigned's name, place & stead to endorse any/all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and said Training Rm Physical Therapy & Fitness, Inc., when which checks, drafts or money orders are made payable for services which have been rendered by Training Rm Physical Therapy & Fitness, Inc. at the request or with the knowledge and approval of the undersigned and / or the make of the check, draft or money order. Furthermore, the undersigned allows Training Rm Physical Therapy & Fitness, Inc. or any of its agents to sign any paper that will be necessary to enhance, expedite and / or allow payment to said provider. This may include insurance forms and / or other forms.

The undersigned by these present does give & grant the said Training Rm Physical Therapy & Fitness as attorney the full power and authority to do and perform all & every act whatsoever requisite & necessary to be done in & about the premises as fully to all intents & purpose as the undersigned might or could do it personally insofar as the endorsing & cashing of said checks are concerned as well as any other document.

Medical Release

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me, the patient, to release true copies of the same to Training Rm Physical Therapy & Fitness, Inc. or any insured providing the coverage to me in connection with the process of any claim for benefits made by me or by the assignee herein. A photocopy of the document shall be binding as an original signature page. The undersigned does hereby ratify and confirm and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these present.

Assignment of Benefits

I, ____, hereby authorize ______________________________________

(Name of Insured / Patient) (Name of Insurance Carrier)

To make payable & mailed directly to: Training Rm Physical Therapy & Fitness, Inc.

900 Glades Road Suite 1E. Boca Raton, FL 33431

The medical benefits otherwise payable to me for their services but not to exceed the charges of those services. I hereby IRREVOCABLY ASSIGN to Training Rm Physical Therapy & Fitness, Inc. any right & benefits under any policy of insurance, indemnity, agreement or any other collateral sources as defined in Florida Statutes for any services and/or charges provided by Training Rm Physical Therapy & Fitness, Inc..

IN WITNESS WHEREOF the undersigned have here unto set their hands, this _____________ day of ______________________

Signature of Patient (patient / guardian, if minor) _________________________ Date:________________________

Patient's Name (Please Print):___________________________________

Therapist Name: Elvis Ramnarace/Liza Tirado

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Insurance

We accept Medicare, all major insurances and numerous PPO & managed care contracts. Please be aware that some and perhaps all, of the services provided may be considered not medically necessary by your insurance provider. You will be responsible for these charges.
Your medical insurance is a contract between you and your insurance company. We are not a party to this contract. Training Rm Physical Therapy & Fitness, Inc. will submit all claims for charges to your insurance provider as a service to you. Co-pays must be paid at time of service in order to abide by your insurance contract. If your policy requires a referral, be sure to have it with you when you come to our office. Failure to obtain & present a referral at the time of service may result in a loss of your insurance benefits. If you need assistance obtaining a referral please ask our Front Desk Coordinator.

Notice of Privacy Practices

Date: ____

Patient Name: ____

This is to certify that I, __________________________________ have been given, offered or have seen the posted copy of the **Notice of Privacy Practices** (also known as HIPPA).

______________________________________ ________________________

Signature of Patient / Guardian Date

______________________________________ ________________________

Signature of TR Representative Date

Office Use Only

I attempted to obtain the Patient's signature in acknowledgement on this Notice of Privacy Practices Form, but was unable to do so as documented below:

Date:	**Initials:**	**Reason:**

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Records Release Form

Date: ______________________________________

To:____
Doctor / Hospital

____
Address

____

I hereby authorize and request you to release my complete medical records, concerning my illness and / or treatment during the period of:

__________________________________ **to** ___________________________________

To: Training Room Physical Therapy & Fitness Inc.
900 Glades Road Suite 1E
Boca Raton, FL 33431
Ph: (561) 826-0334 Fax: (561) 826-0376

Name: ____

Date: ____

Signed: ____
Signature of Patient / Guardian if patient is a minor