Strive!
HEALTH & REHABILITATION

# NEW PATIENT REGISTRATION FORM

Patient's Full Name_____
Last First Middle Initial

Street Address_____
City State Zip

Mailing Address_____
City State Zip

Home Phone_____ Work Phone_____

Cell Phone _____ Date of Birth_____

Sex ☐ Male ☐ Female ☐ Other **Date of Injury**_____

Patient Marital Status: ☐Single ☐Married ☐Widowed ☐ Divorced ☐Other

**EMAIL ADDRESS**_____
**[] I consent to receive emails from Strive! [] I DO NOT consent to receive emails from Strive!**

☐**Work Comp Claim** ☐**Auto Claim, State**_____ ☐**Attorney**_____

**Are you currently receiving ANY Home Health Services ☐ Yes ☐ No**

**Employer / Company at time of injury:**

Name_____Phone#:_____

Street Address_____
City State Zip

**WHO MAY WE CONTACT IN CASE OF EMERGENCY?**

Name_____ Phone Number_____
Relationship_____

**INSURANCE INFORMATION** (check one please) ☐ MC ☐ Tricare/Champus ☐ Auto ☐ BC/BS

Last 4 of social: _____ ☐ WC ☐ Medicaid ☐ Commercial ☐ UHC

Subscriber's Name If different than patient_____DOB_____

Insurance Name_____
Subscriber's Number_____ Group Number_____
Employer Name_____
Street Address_____
City State Zip

Secondary Insurance_____

**AUTHORIZATION FOR TREATMENT**

I authorize Strive! Health and Rehabilitation, its employees and agents as well as any and all independent contractors engaged by Strive! Health and Rehabilitation to perform the services on my behalf as they may deem necessary.
I have authorized direct payment from my insurance plan to Strive!

Signature_____ Date_____

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# AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION AND AUTHORIZATION OF ASSIGNMENT OF BENEFITS

We feel strongly that all patients deserve the very best medical care we can provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our policy. Our professional services are rendered to you, not the insurance company. Therefore, payment for treatment is your responsibility.

## PLEASE READ AND INITIAL THE FOLLOWING:

_____ I authorize this office to release or receive any information necessary to expedite insurance claims.

_____ I hereby authorize this office to bill my insurance company directly for their services

_____ I authorize payment directly to this provider of my insurance benefits otherwise payable to me

_____ In the event I receive payment from my insurance carrier, I agree to endorse any payment over to the provider for which these fees are payable

_____ I hereby authorize the Strive! Health and Rehabilitation physical and occupational therapist (s) to release information regarding services rendered by them and allow a photocopy of my signature to be used to file insurance. I hereby authorize Strive! Health and Rehabilitation to perform any service (evaluation, treatment procedures, and testing) necessary for my rehabilitation

_____ Strive! Health and Rehabilitation is granted permission to release to the insurance carrier, employer, attorney, their representatives or referring physician, any information in connection with any treatment rendered to patient or on patient's behalf at any time such information is requested.

_____ **HIPAA**: I have received the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

I understand that I am directly and completely responsible to this provider for charges not covered by my insurance. I further understand that such payment is not contingent on any settlement, judgment, or insurance payment by which I eventually recover said fee.

A Photostat copy of these authorizations and agreements shall be as valid as the original.

_____ _____ _____

Patient or Guardian (print) Patient or Guardian (signature) Date

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# Medicare Secondary Payor (MSP) Form

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

| Part 1: | | |
|---|---|---|
| 1. Are you currently receiving benefits under Black Lung Program?<br>If yes when did benefits begin: | Yes | No |
| 2. Was this injury/illness due to work-related accident/condition?<br>If yes when did injury accident occur: | Yes | No |
| 3. Was injury/illness covered under no fault medical payment coverage?<br>If yes Date of Accident: | Yes | No |
| 4. Was this Injury/Illness related to an accident in which you intend to file the liability suit or litigation pending?<br>If yes please provide<br>Attorney Name:<br>Address:<br>Phone Number: | Yes | No |
| **Part 2** | | |
| 1. Are you entitled to Medicare base on | | |
| • Age (65 & older) | Yes | No |
| • Disability | Yes | No |
| • End Stage Kidney Disease or Kidney Dialysis | Yes | No |
| 2. Do you currently have a group health plan (GHP) coverage based on your own current employment, or the current employment of either yourself, spouse or family member? | Yes | No |
| **Part 3** *Medicare benefits are secondary to benefits payable under a GHP for individuals eligible for or entitled to benefits on the basis of ESRD during a period of up to 30-month period if Medicare was not the proper primary payer for the individual on the basis of age or disability at the time that this individual became eligible or entitled to Medicare on the basis of ESRD.* | | |
| 1. Do you have Group Health Plan Coverage | Yes | No |
| 2. Are you with in 90 day coordination period? | Yes | No |

**Signature of Patient:** _____ **Date:** _____

**Witness:** _____

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To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question leave it blank and your therapist will assist you. ***Thank you!***

Name:_____ Leisure Activities:_____

Age:_____ Occupation:_____

**ALLERGIES:** List any medication(s) you are allergic to:_____

Are you latex sensitive? Yes No List any other allergies we should know about:_____

Have you declared the Advanced Clinical Directive of Do Not Resuscitate? Yes No

Do you have a pacemaker? Yes No

Please check ( √ ) any of the following whose care you're under

___Medical doctor ( MD )
___Osteopath
___Dentist
___Psychiatrist/Psychologist
___Physical Therapist
___Chiropractor
Other_____
_____

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc...)

_____

_____

Have you **EVER** been diagnosed as having any of the following conditions?

YES NO Cancer. If YES, describe what kind:_____
YES NO Heart Problems
YES NO High Blood Pressure
YES NO Circulation Problems
YES NO Asthma
YES NO Emphysema/Bronchitis
YES NO Chemical Dependency (i.e. alcoholism)
YES NO Thyroid Problems
YES NO Diabetes
YES NO Multiple Sclerosis
YES NO Rheumatoid Arthritis
YES NO Other Arthritic Conditions
YES NO Depression
YES NO Infections (positive blood test for Hepatitis, HIV, AIDS)
YES NO Tuberculosis
YES NO Stroke, TIA
YES NO Kidney Disease
YES NO Anemia
YES NO Epilepsy
YES NO Other

For Office Use

During the past month have you been feeling down, depressed or hopeless? YES NO
During the past month have you been bothered by having little interest or pleasure in doing things? YES NO
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO
**FOR WOMEN:** Are you currently pregnant or think you might be pregnant? YES NO

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

| | DATE | REASON FOR SURGERY/HOSPITALIZATION |
|---|---|---|
| 1. | _____ | _____ |
| 2. | _____ | _____ |
| 3. | _____ | _____ |
| 4. | _____ | _____ |

OVER→

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We are able to remind you of your appointment by phone call, e-mail or by text message to your mobile phone.

Please select one of the following:

_____ Remind me by phone call. My phone Number is _____.

_____ Remind me by e-mail. My e-mail is _____.

_____ Remind me by text message. My mobile number is _____
and my mobile phone carrier is _____.

Thank You!!
Strive Health & Rehab.

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# How did you hear about us?

**PLEASE BE AS SPECIFIC AS POSSIBLE.....**

**Doctor** _____

**Friend/Relative** _____

**Previous Patient** _____

**Advertisement (ex: magazine, directory)** _____

**Website** _____

**Internet (ex: Google search)** _____

**Social Media (ex: Facebook, Twitter)** _____

**Brochure** _____

**Event (ex: healthfair, community event, presentation)**

_____

**Phone Book** _____

**Employee** _____

**Other** _____