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

Patient Marital Status: Single Married Widowed Divorced Other :

Are you currently receiving ANY Home Health Services: Yes No

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_____

Employer / Company at time of injury:

Name:_____ Phone#:_____

Street Address_____
City State Zip

WHO MAY WE CONTACT IN CASE OF EMERGENCY?

Name_____ PhoneNumber_____ Relationship_____

INSURANCE INFORMATION

Subscriber's Name If different than Patient_____ DOB_____
Insurance Name_____
Subscriber's Number_____ Group Number_____
Employer Name_____
Secondary Insurance_____

Primary Care Physician: _____ Phone Number: _____

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

Cancellation/No Show Policy

Name:_____

Strive requires a 24 hour notice for all cancellations. A successful therapy treatment program depends on the schedule outlined by your therapist for best results. If 24 hour notice is not given please do your best to give as much notice as possible if you are unable to attend your appointment or will be late.

- *2 or more no show/cancel may result in removal from schedule and possible discharge.*
- *Arriving 15 minutes past your scheduled time may result in a reschedule if time is not allotted or a shorter visit.*
- *You will be responsible for your copay if you are late and agree to shorter appointment time.*
- *If your physician has placed you on a therapy "hold" please notify our office immediately so we can remove you from the schedule.*
- *Please update any phone numbers that may change so we have up to date information on file.*

Thank you for your commitment to your therapy program and working together to make it successful for yourself and others.

Patient/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? If yes when did benefits begin:	Yes	No
2. Was this injury/illness due to work-related accident/condition? If yes when did injury accident occur:	Yes	No
3. Was injury/illness covered under no fault medical payment coverage? 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? If yes please provide Attorney Name: Address: 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
Please provide copy of your group health insurance if determined to be primary.		

Signature of Patient:_____Date:_____
Witness:_____

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HEALTH & REHABILITATION

Medical History Questionnaire

Name:_____Age:_____Leisure Activities Hobbies:_____

Current/Previous Occupation:_____Right Handed_____Left Handed_____

Please check (√) any of the following care you are under

_____Medical Doctor _____Phycologist/Psychiatrist _____Dentist _____Other:_____

_____Osteopath _____Physical Therapist _____Chiropractor_____

If you have seen any of the above, briefly describe for what reason (illness, medical condition, ect.)

_____

ALLERGIES: List medication allergies:_____

Are you Latex Sensitive: YES NO List any other allergies you know of:_____

Do you have a pacemaker: YES NO

Have you declared the Advanced Clinical Directive of Do Not Resuscitate? YES NO

Have you Ever Been Diagnosed with Having the Following Conditions:

YES NO Cancer: IF Yes: What Kind:_____

YES NO Heart Problems
YES NO High Blood Pressure
YES NO Circulation Problems
YES NO Asthma
YES NO Emphysema/Bronchitis
Yes NO Thyroid Problems
YES NO Diabetes Type 1 or 2
YES NO Multiple Sclerosis
YES NO Rheumatoid Arthritis
YES NO Arthritis
YES NO Depression
YES NO Blood Clots
Yes NO Tuberculosis
YES NO Stroke/TIA
YES NO Kidney Disease
YES NO Anemia

YES NO Vision Problems
YES NO Parkinson's
YES NO Seizures
YES NO Speech Problems
YES NO Hearing Loss
YES NO Fractures: _____
YES NO Hepatitis
YES NO Hearing Loss
YES NO Osteoporosis
YES NO HIV/AIDS

OFFICE USE ONLY

Patient Signature:_____ Date:_____
Therapist Signature:_____ Date: _____

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CURRENT MEDICATION LIST (Including pills, injections, patches/creams)

1. _____	4. _____	7. _____
2 _____	5. _____	8. _____
3 _____	6. _____	9. _____

SOCIAL HISTORY/WELLNESS

Do you Drink Alcohol: YES NO How many per day/week? _____

Use of Tobacco Products YES NO How many per day/week? _____

Do you Exercise Daily/Weekly YES NO How Often? _____

Do you live ALONE w/SPOUSE CHILD OTHER? _____

PAST SURGICAL HISTORY List all previous Surgeries/Injuries/Hospitalizations

1. _____	4. _____	7. _____
2 _____	5. _____	8. _____
3 _____	6. _____	9. _____

CURRENT CONDITION

Why are you seeking physical therapy, briefly describe the nature of your problem? _____

_____

_____

Have you had any Falls Recently? YES NO If so When: _____

Have you had therapy for this problem before: YES NO

Are your symptoms worse in the MORNING AFTERNOON NIGHT

Is your Pain/Problem getting WORSE BETTER SAME

Are your Symptoms CONSTANT OCCASIONAL SELDOM/NOT OFTEN

What is your goal for therapy treatments? _____

OFFICE USE ONLY

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

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

Please SELECT ONLY 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 _____

Patient Signature:

Thank You!!
Strive Health & Rehab

How did you hear about us?

Doctor Name: _____

Friend/Relative Name: _____

Previous Patient: _____

Advertisement: _____

Website: _____

Internet Search: _____

Social Media: _____

Brochure: _____

Event: _____

Employee: _____

Other: _____