



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 _____ Phone Number _____ 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 _____



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 authorize Strive Rehab to discuss my healthcare information, billing/payment for services to person:

Name: _____ Relationship: _____ Date: _____

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

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

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: _____



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 Vision Problems

YES NO High Blood Pressure YES NO Parkinson's

YES NO Circulation Problems YES NO Seizures

YES NO Asthma YES NO Speech Problems

YES NO Emphysema/Bronchitis YES NO Hearing Loss

Yes NO Thyroid Problems YES NO Fractures: _____

YES NO Diabetes Type 1 or 2 YES NO Hepatitis

YES NO Multiple Sclerosis YES NO Hearing Loss

YES NO Rheumatoid Arthritis YES NO Osteoporosis

YES NO Arthritis YES NO HIV/AIDS

YES NO Depression

YES NO Blood Clots

Yes NO Tuberculosis

YES NO Stroke/TIA

YES NO Kidney Disease

YES NO Anemia

OFFICE USE ONLY

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

**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 CONDITIONWhy 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: _____



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. Also, subject to **\$50** fee.*
- *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: _____



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: _____