PHYSICAL THERAPY & INJURY SPECIALISTS
Staying Active for WORK. SPORT. LIFE.

PATIENT REGISTRATION

Patient Name: ______________________________ Date: ____________

SSN: _______________ DOB: _______________ Sex: ☐M ☐F

Address: ____

City: ____________________________ State: ____________ Zip: _________

Phone Numbers (please mark preferred):

Home: ☐_______________ Cell: ☐_______________ Work: ☐_______________

Email: _____________________________________

Would you like text or email reminders? ☐Email ☐Text

Cell Phone Carrier ☐ ATT ☐ Verizon ☐ Other _______________

Please Note: Text reminders to Cricket customers will not work.
Please add denverptis@turbopt.com to avoid reminders going to your junk box

Emergency Contact: ___________________________Relationship: _______________

Home Phone: ____________________ Other Phone: _____________________

PHYSICIAN INFORMATION

Referring Physician: ____

Phone: ____________________________ Fax: ______________________________

Primary Physician: ____

Phone: ____________________________ Fax: ______________________________

INSURANCE INFORMATION

Health Insurance Carrier: ____

Phone: ____________________________ Fax: ______________________________

Address: ____

Policy ID: ___________________________ Group #: ___________________________

Primary Insured: ______________________ Primary Insured DOB: __________________

Relationship to Patient: __________________

EMPLOYMENT INFORMATION

Employer: ____

Employer Address: ____

Employer Phone: __________________

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PHYSICAL THERAPY & INJURY SPECIALISTS — PTIS — HD PT
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We are a small business and would like to understand and THANK the person who recommended us to you. The person who recommended us may be different from the doctor that gave you a referral order. Please help us thank the right person by filling in the items below:

How did you find out about PTIS/HDPT?

☐ **Physicians Group.** If you checked this, who specifically told you about us?
- ☐ Physician (MD/DO)
- ☐ Physician's Assistant (PA)
- ☐ Nurse Practitioner (NP)
- ☐ Medical Assistant (MA)
- ☐ Front Desk of physician

Name of person checked above: ________________________________

☐ **Work Comp Case Manager.** Name: ________________________________

☐ **Social Media**
- ☐ PTIS Newsletter
- ☐ PTIS website
- ☐ Instagram
- ☐ Facebook
- ☐ Twitter

☐ **Personal Referral**
- ☐ Friend
- ☐ Family Member
- ☐ PTIS Staff Member
- ☐ Personal Trainer
- ☐ Massage Therapist
- ☐ Athletic Trainer
- ☐ Pilates Instructor
- ☐ Other

Name of person checked above: ________________________________

☐ **Insurance Company.** Our name was listed as part of your network

☐ **Employer.** Your employer gave you our name/number.

☐ **Location.** We were the most convenient clinic for you.

Any other information you would like to provide about how you found us? ______________________________
____
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PTIS PATIENT AGREEMENT

CONSENT TO TREAT

I hereby consent to evaluation and treatment by PTIS and/or its clinical staff for either my dependent or myself. I understand there are certain risks associated with any examination and treatment and those risks will be presented and explained to me during the evaluation.

__________ Initials

RELEASE OF INFORMATION

I give permission to PTIS to release information, verbal and written, contained in my medical record, and other related information to my insurance company, attorney employer, school, related healthcare provider, assignee, and/or beneficiaries and all other related persons as it relates to my treatment. I authorize PTIS to obtain medical records and/or professional information from my physician or other medical professionals, attorney and insurance company as it relates to my treatment and/or claim.

__________ Initials

CHECK-IN TIME

Patients are required to arrive fifteen (15) minutes prior to their scheduled appointment time. This is considered your check-in time and is true for all appointments through the course of treatment. Arriving late to your check-in time may result in a delay of appointment. Please note, you may be asked to arrive more than ten (10 minutes prior to your scheduled appointment for initial and re-evaluation for completion of paperwork.

__________ Initials

LATE APPOINTMENT/NO SHOW POLICY

This notice is to inform all patients that they must arrive on time or early to all appointments. Any patient arriving ten (10) minutes after the scheduled appointment time or later will be asked to reschedule their appointment. If a patient arrives late or does not show up to their appointment without 24-hour prior notice, it will result in **$40 fee** applied to the patient responsibility balance. This charge is not covered by insurance. If you are aware that you will be running late or unable to make your appointment, please call our front office at 303-757-1554 to notify us of the delay or cancellation. Adherence to this policy shows respect for both our clinicians and our other patients.

__________ Initials

CANCELLATION/RESCHEDULE POLICY

PTIS understands that there are times when you are unable to make a schedule appointment due to other obligations. However, when you do not call to cancel an appointment, you may be preventing another patient from getting needed treatment. Please notify our office 24 hours prior to your appointment if cancellation or rescheduling is required. If our office is not notified 24 hours prior to your appointment, it will result in a $40 fee applied to the patient responsibility balance. This charge is not covered by insurance.

__________ Initials

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INSURANCE

PTIS is an in-network provider for a majority of healthcare plans. PTIS also accepts insurances plans that have out-of-network benefits available, but this may results in higher out of pocket costs to the patient. Please note that verification and review of patient benefits is not a guarantee of payment by the patient's insurance company. Knowing your insurance benefits is the patient's responsibility. PTIS is happy to answer patient questions about insurance, but we highly recommend that patients contact their insurance company directly for the most up-to-date information.

Please be aware that the balance of the patient's claim is the patient's responsibility whether or not the insurance company pays the claim. The patient's insurance benefit is a contract between the patient and their insurance company. PTIS is not party to that contract. It is the patient's responsibility to notify PTIS of any changes with insurance. Failure to do so may result in denied claims which then result is higher payments for the patient. **We verify your insurance as a COURTESY, this is not a guarantee of benefits. You are responsible for knowing your insurance and are financially responsible for any services not covered.**

______ Initials

CO-PAYS & CO-INSURANCE

Patients are required to pay all copays, co-insurance, and past due balances at the time of check-in, unless previous arrangements have been made. PTIS accepts cash, checks and credit cards.

______ Initials

MOTOR VEHICLE ACCIDENT (MVA) AND OTHE THIRD-PARTY BILLING

PTIS does not accept any third-party billing. Our relationship is with the patient and not with the third party liability insurance. It is the patient's responsibility to seek reimbursement from their third-party insurance. PTIS does, however, accept MedPay through the patient's auto insurance.

______ Initials

SELF-PAY RATE

For patients without insurance and/or patients who have insurance that is out-of-network with PTIS, we offer a Self-Pay Rate. The Self-Pay Rate is available upon request. Self-Pay Rates cannot be billed to insurance.

______ Initials

NON-PAYMENT

If the balance on a patient's account is ninety (90) days or more past due, if the patient does not contact us about the balance, or respond to our efforts to contact the patient, and/or if the patient does not make agreed upon payments via a pre-approved payment plan, the patient's account balance will be subject to placement in an outside collections agency and associated late/non-payment fees. Please note that the accounts placed for outside collection are no longer eligible to apply for a reduction based on need. If the patient's account balance is placed for outside collection, the unpaid amount will be reported to credit bureaus by our contracted collection agency. The patient will be responsible for all reasonable collection fees, attorney fees, and filing processing costs.

______ Initials

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ASSIGNMENT OF BENEFITS AND PAYMENT GUARANTEE

I, or the patient, authorize payment directly to PTIS for rendered services. This is a direct assignment of my rights and benefits under this policy. I agree to immediately forward any reimbursements to PTIS that I receive that are issued for the purpose of payment for treatment. I understand that any information obtained by PTIS for the purpose of payment of claims is not a guarantee of coverage and/or benefits. I agree to make every effort to remain informed about the extent and/or limitations of my insurance coverage and will adhere to any requirements by my insurance company in order to facilitate payment of my claims. Where the laws or insurance contract does not prohibit payment to me, I acknowledge responsibility for any and all account balances, legal fees, any and all interest charges, and any other expense incurred in collecting the patient's account balance.

_______________________________ _______________

Patient Signature Date

AUTHORIZATION FOR USE OF PERSONAL HEALTH INFORMATION (PHI)

I agree to allow information from my PHI, after marking it anonymous and removing any identifying features, to be disclosed for optional substudies or research activities associated with determining the merits of physical therapy intervention.

_______________________________ _______________

Patient Signature Date

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PHYSICAL THERAPY & INJURY SPECIALISTS

PTIS HD PT

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MEDICAL HISTORY QUESTIONNAIRE

Patient Name: ______________________________

Have you been treated in our office before? Yes No

Known Allergies: ______________________________

Current Medical Conditions: ______________________________

☐ AIDS/HIV	☐ Concussion/ Head Injury	☐ Headaches/ Migraines	☐ Loss of appetite	☐ Spinal Cord Injury
☐ Arthritis	☐ Cortisone Meds	☐ Heart Attack/ Heart Failure	☐ Multiple Sclerosis	☐ Spinal Stenosis
☐ Artificial Joint	☐ Depression	☐ Hepatitis A/B/C/D	☐ Osteoarthritis	☐ Stomach/ Intestinal Disease
☐ Asthma	☐ Diabetes	☐ Herniated Disc/ Bulging Disc	☐ Osteoporosis	☐ Thyroid Disease
☐ Blood Disease	☐ Emphysema	☐ High/Low Blood Pressure	☐ Pain in Jaw/TMJ	☐ Tobacco Use
☐ Bruise Easily	☐ Epilepsy/Seizures	☐ Kidney Problems	☐ Pregnancy	☐ Rheumatism
☐ Cancer	☐ Excessive Bleeding	☐ Liver Disease	☐ Recent Weight Loss	☐ Scarlet Fever/ Rheumatic Fever
☐ Chemotherapy	☐ Fainting/ Dizziness	☐ Fibromyalgia/ Myofascial Pain	☐ Renal Dialysis	☐ Shortness of Breath
☐ Chest Pains	☐ Falls	☐ Fractures		

Have you ever been hospitalized or had surgery? Y ○ N ○

If yes, please list:

Are you taking any medications, pills or drugs? Y ○ N ○

If yes, please list:

Have you ever had any illness not listed above? Y ○ N ○

If yes, please list:

Patient Goals:

- **Improve Sleep** ☐
- **Decrease Pain** ☐
- **Improve self care** ☐
- **Improve cooking/kitchen ability** ☐
- **Improve lawn mowing/gardening ability** ☐
- **Improve reaching/pulling/pushing ability** ☐
- **Improve lifting/carrying ability** ☐
- **Increase sitting/standing tolerance** ☐
- **Improve bending/squatting tolerance** ☐

O **ther - Please list:**

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Patient Health Questionnaire - PHQ

Patient Name molloy

1. Describe your symptoms ______________________

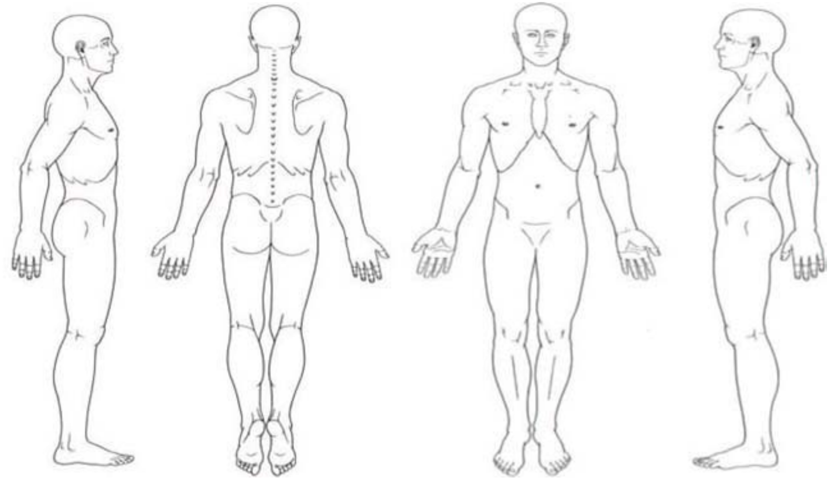
a. When did your symptoms start ______________________

b. How did your symptoms begin? ______________________

2. How often do you experience your symptoms?

- ◯ Constantly (76-100% of the day)
- ◯ Frequently (51-75% of the day)
- ◯ Occasionally (26-50% of the day)
- ◯ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

- ☐ Sharp
- ☐ Shooting
- ☐ Dull ache
- ☐ Burning
- ☐ Numb
- ☐ Tingling

4. How are your symptoms changing?

- ◯ Getting Better
- ◯ Not Changing
- ◯ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ *Unbearable* ◯

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

◯ Not at all ◯ A little bit ◯ Moderately ◯ Quite a bit ◯ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

◯ All of the time ◯ Most of the time ◯ Some of the time ◯ A little of the time ◯ None of the time

7. In general would you say your overall health right now is...

◯ Excellent ◯ Very Good ◯ Good ◯ Fair ◯ Poor

8. Who have you seen for your symptoms?

◯ No One ◯ Chiropractor ◯ Medical Doctor ◯ Physical Therapist ◯ Other

a. What treatment did you receive and when? ______________________

b. What tests have you had for your symptoms and when were they performed?

◯ Xrays *date:* __________ ◯ CT Scan *date:* __________
◯ MRI *date:* __________ ◯ Other *date:* __________

9. Have you had similar symptoms in the past?

◯ Yes ◯ No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

◯ This Office ◯ Chiropractor ◯ Medical Doctor ◯ Physical Therapist ◯ Other

10. What is your occupation?

◯ Professional/Executive ◯ White Collar/Secretarial ◯ Tradesperson ◯ Laborer ◯ Homemaker ◯ FT Student ◯ Retired ◯ Other

____

a. If you are not retired, a homemaker, or a student, what is your current work status?

◯ Full-time ◯ Part-time ◯ Self-employed ◯ Unemployed ◯ Off work ◯ Other

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Patient Name: ________________________ ________________________

Patient Specific Functional Scale

This survey is used to determine your functional abilities and limitations so we can direct treatment appropriately and track your progress.

Please identify at least 3 important activities that you are unable to do or are having difficult with as a result of your injury/problem. After identifying the activity, please rate your difficulty according to the scale below.

Patient Specific Activity Scoring scheme (score one number for each activity):

Scoring: 0 1 2 3 **4** 5 6 7 8 9 10 (0=UNABLE to do activity,10 =NORMAL)

Activity	Initial Date:	Follow-up Date:	Follow-up Date:	Follow-up Date:	Follow-up Date:
1.	Score(1-10):	Score(1-10):	Score(1-10):	Score(1-10):	Score(1-10):
2.	Score(1-10):	Score(1-10):	Score(1-10):	Score(1-10):	Score(1-10):
3.	Score(1-10):	Score(1-10):	Score(1-10):	Score(1-10):	Score(1-10):
4.	Score(1-10):	Score(1-10):	Score(1-10):	Score(1-10):	Score(1-10):
5.	Score(1-10):	Score(1-10):	Score(1-10):	Score(1-10):	Score(1-10):

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