TENNESSEE THERAPY & BALANCE CENTER, LLC

## REGISTRATION FORM

Today's Date:____/____/_____ Estimated onset date of symptoms of which you are receiving therapy:____/____/_____

## PATIENT INFORMATION

First Name:_____ Last Name:_____ MI:_____

Date of Birth:___/_____/_____ Age:____ Sex: M F Social Security #:_____-____-_____

Marital Status:_____ Occupation:_____ Employer:_____

Home/Mailing Address:_____

City:_____State:_____ Zip Code:_____

Home:_____-_____-_____ Cell/Other:_____-_____-_____ Referring Physician:_____
*(Please circle preferred method of phone contact)*

Is the condition for which you are referred to therapy related to an auto accident or worker's compensation? YES NO

Have you received outpatient physical, occupational, or speech therapy in 2020? YES NO

Are you currently receiving home healthcare? YES NO

## INSURANCE INFORMATION

Please give your insurance card(s) to the receptionist

Primary Insurance:_____ Patient's Relationship to Subscriber:_____

Subscriber's Name:_____ Subscriber's Date of Birth:___/___/_____
(if different from Patient) (if different from Patient)

Secondary Insurance:_____ Patient's Relationship to Subscriber:_____

Subscriber's Name:_____ Subscriber's Date of Birth:___/___/_____
(if different from Patient) (if different from Patient)

## IN CASE OF EMERGENCY

Name of local relative or friend:_____Relationship:_____Phone #:_____-_____-_____
(living at different address)

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the facility. I understand that I am financially responsible for any balance. I also authorize Tennessee Therapy & Balance Center, LLC or insurance company to release any information required to process my claims.

Patient/Guardian Signature: _____ Date:_____/_____/_____

Name:_____Date:_____

Height:_____ Weight:_____

| | | | |
|---|---|---|---|
| Heart Issues | YES or NO | Cancer | YES or NO |
| Pacemaker | YES or NO | Asthma | YES or NO |
| Diabetes | YES or NO | Joint surgery | YES or NO |
| MRSA/ Staph | YES or NO | Back Surgery | YES or NO |
| Stroke/ TIA | YES or NO | Neck Surgery | YES or NO |
| Recent Falls | YES or NO | Head Injury | YES or NO |
| (Defined as 2 or more falls in the past year or any fall with injury in the past year) | | Pain Scale (If Applicable) | Worse (0-10) _____<br>Best (0-10) _____ |

Recent MRI, CT, or X-rays concerning your visit today? YES NO

Area of body and which facility:_____

Signature:_____ Date:_____

Patient Name: _____ DOB: _____

TENNESSEE THERAPY & BALANCE CENTER, LLC

## Informed Consent for Treatment

I (we) voluntarily consent and authorize Tennessee Therapy & Balance Center, LLC, its physical therapists, physical therapy assistants, and other health care providers as they may deem necessary, to perform an evaluation, give advice, and to provide treatments/ procedures for my condition which has been explained to me. I (we) understand that my physical therapist may discover other or different conditions which require additional or different procedures than those planned and may require consent from my physician before such additional or different procedures are utilized. I (we) authorize Tennessee Therapy & Balance Center, LLC, its physical therapists, physical therapy assistants, and other health care providers as they may deem necessary with consent from my physician to perform such other procedures which are advisable in their professional judgment.

I (we) understand that no warranty or guarantee has been made to me as to result or cure. Just as there may be risks and hazards in continuing my present condition without treatment, there is a potential risk, although rare, of side effects related to the performance of the physical therapy evaluation and treatment/ procedures planned for me.

I have read the foregoing and I understand it. I consent to a physical therapy evaluation, advice, and treatment/ procedures as prescribed by my provider or through self referral (direct access).

**Patient/ Guardian Signature:** _____ **Date:** _____

TENNESSEE THERAPY
& BALANCE CENTER, LLC
KAREN HANSEN, PT, DPT

675 C South Jefferson Avenue
Cookeville, TN 38501
p (931) 528-8822 f (931) 528-8825
www.therapyandbalance.com
ttbc@therapyandbalance.com

# MEDICATION LIST

Patient Name: _____ Date: _____

| MEDICATION | DOSE | FREQUENCY | ROUTE OF ADMINISTRATION (circle one) |
|---|---|---|---|
| | | | oral/ injection/ patch/ sublingual |
| | | | oral/ injection/ patch/ sublingual |
| | | | oral/ injection/ patch/ sublingual |
| | | | oral/ injection/ patch/ sublingual |
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Patient Name: _____ DOB: _____

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## Patient HIPAA Acknowledgment and Release of Information

### Notice of Privacy Practices

I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

### Release of Information

I give my authorization for treatment records to be released to the responsible payor for reimbursement consideration, or medical facility necessary for treatment or further care. Additionally, I request that any medical records requested by this facility, necessary for treatment or further care, be forwarded to this facility upon its request.

I understand that I am financially responsible for all charges whether or not paid for by said insurance (i.e. deductible amounts, co-insurance, co-pay, or any other balance not paid by my insurance). If this account is assigned to an attorney for collection and/or suit, the facility shall be entitled to reasonable attorney's fees and costs of collection.

I request that payment of authorized benefits be made on my behalf to this facility. I assign the benefits payable to which I am entitled to this facility for services rendered. This assignment will remain in effect until revoked by me in writing. A photocopy and/or facsimile of this assignment is to be considered as valid as an original.

### Disclosures to Friends and/or Family Members

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings, and care decisions to the family members and others listed below:

1:

2:

3:

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