PATIENT REGISTRATION FORM

Patient Name: _____ DOB: _____ Evaluation Date: _____

Home Address: _____

Phones: Home _____ Work: _____ Cell: _____

Email: _____ Occupation: _____

Emergency Contact: _____ Relationship_____ Phone _____

Responsible Party: _____ Relationship_____ Phone _____

Referring /Primary Care Physician Name _____ Diagnosis _____

With whom may we discuss your account or medical information? _____

Who may we thank for referring you to our office? _____

INSURANCE INFORMATION *(Do not fill if you have already provided us with CURRENT insurance card!)*

Please provide all your current insurance cards to our front office.

Motor Vehicle Accident Information (only if applicable)	**Worker's Compensation Information (only if applicable)**
Date of Accident: _____ Nature of Accident: _____ State Where Accident Occurred: _____ Attorney: _____ Phone: _____	Is this injury related to work? ___ Yes ____ No Date of injury: ___/____/_____ WC Contact/Claims Mgr:_____ Phone: _____

FINANCIAL POLICY ***Initial:_____***

I have been notified and understand the following financial policies and responsibilities:

- I accept full financial responsibility for treatment received at this facility.
- I understand that payment of pre-determined office visit deductible, co-pay and co-insurance estimates are due at the time of service.
- I understand that my insurance may only cover a percentage of my total Physical Therapy bill. I agree to pay Orthocare Physical Therapy Center all amounts that are due and owing for services provided which are not otherwise paid for by Medicare, a third party insurance plan, or other payor source, on my behalf for services rendered. In the event that this account is referred to a collection agency or an attorney, the undersigned further agrees to pay all reasonable costs of collection including, but not limited to, reasonable attorney's fees.
- If there is balance remaining at the end of treatment, I will receive one courtesy statement. I understand payment is due within 30 days from the date I am billed. Account balances are subject to a monthly service charge of 1.5%.
- I understand that I will be charged a fee of $50.00 if I do not cancel atleast 48 hours prior to my scheduled appointment time.
- I understand that a "No-Show" for scheduled appointment will result in $50.00 charge to my account.
- I understand that I am responsible for notifying the business office of any address or insurance changes to my account.
- I allow my credit card on file to be charged for any / all expenses accrued throughout my treatment at Orthocare Physical Therapy Center, LLC not limited to copays, co-insurance, deductibles, supplies, and no-show/cancellation fees.

PATIENT REGISTRATION FORM

Patient Name: _____ DOB: _____ Evaluation Date: _____

HIPAA POLICY *Initial:_____*

I understand that under the Health Insurance Portability & Accountability Act (HIPAA), I have certain rights related to protecting my personal health information. I understand that my personal information will be used to:

- Help manage and administer the health care treatment received (including follow-up among multiple healthcare providers who may be directly or indirectly involved in the treatment.)
- Run the organization (including marketing)
- Obtain payment for rendered health services
- Do research
- Address workers' compensation, law enforcement, and other government requests (if applicable)
- Comply with the law

I acknowledge that I received, read, and understand the NOTICE OF PRIVACY PRACTICES which contains a thorough description of the uses and disclosures of my private health information.

PATIENT ACKOWLEDGMENT AND AUTHORIZATION OF RELEASE *Initial:_____*

The above information is true to the best of my knowledge. I authorize Orthocare Physical Therapy Center, LLC to apply for insurance benefits on my behalf and request payment of medical insurance benefits be made directly to the practice for services rendered. I understand that I am financially responsible for any balance. I also authorize Orthocare Physical Therapy Center or insurance company to release any information required to process my claims.

CONSENT TO TREATMENT *Initial:_____*

I consent to receiving outpatient physical therapy services for myself (or my child) and any ancillary services that are deemed medically necessary or appropriate by my physical therapist for all cases and episodes of care this year.

AUTHORIZATION OF COMMUNICATION MEANS

We may need to contact you. Please inform us about your preferred method of communication:

☐ Phone: _____.
Do we have your permission to leave a confidential message at this number? ___Yes ___ No

☐ Email: _____

AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

I hereby authorize Orthocare Physical Therapy Center to disclose my personal health information to the person(s) named below.

Name _____Relationship_____ Phone# _____

Name _____Relationship_____ Phone# _____

Patient Agreement: I understand and agree to comply the above-stated policies at Orthocare PT Center.

Signature _____ **Date:** _____

ORTHOCARE
PHYSICAL THERAPY CENTER

PATIENT REGISTRATION FORM

Patient Name: _____ DOB: _____ Evaluation Date: _____

SUBJECTIVE

1. General Info: Age: _____ years Weight: _____ lbs Height: ____ ft ___ in
2. Please list the symptoms for which you are seeking PT: _____
3. When did you first notice these symptoms? _____
4. How did your symptoms start? _____
5. Are your symptoms: Improving ____ Getting worse____ Staying the same ____
6. On a scale of 0-10 (0 = No pain; 10 = Worst pain), what is your pain level? At best: _____ At worst: _____ Average: _____
7. Have you had these symptoms in the past? Yes _____ No _____
8. Have you received any treatment for these symptoms from another healthcare provider? Yes ____ No _____

   Please describe: _____
9. Have you ever had testing for these symptoms? (*check all that apply)*

   XRays ___ MRI ___CT Scan ____ EMG/Nerve Conduction Studies ____Other_____Results: _____
10. Have you experienced any falls in the last 12 months? Yes ____ No ____
11. What are your **top 3 goals** with physical therapy? (*example*: performing household tasks without pain)

_____

MEDICAL HISTORY

In terms of your general health, please check ALL that apply:

□ Allergies	□ Seizures/Epilepsy	□ Chest Pain/Angina
□ Metal Implants/Artificial Joints	□ Recent Dizziness/Fainting	□ Hernia
□ Respiratory Problems	□ Recent Change in Bowel/Bladder Habits	□ Depression
□ High Blood Pressure	□ Pregnancy (Currently)	□ Surgeries
□ Unexplained Weight Loss/Gain	□ Recent Unexplained Fatigue	□ Heart Disease
□ Diabetes I or II	□ Fibromyalgia	□ Numbness/Tingling
□ Heart Attack	□ Night Pain	□ Pacemaker
□ Osteoarthritis/ Osteoporosis	□ Stroke/TIA	□ Cancer
□ Rheumatoid Arthritis	□ Recent Fractures	□ Other _____

MEDICATIONS

Please provide a list **all** of the medications [with specific NAME, DOSAGE, FREQUENCY, and ROUTE (ie: by mouth)] that you are currently taking [including over-the-counter, prescriptions, herbals, and vitamins/mineral(s)]: □ **See Attached List**

_____

_____

Patient's Signature: _____ PT Signature _____ Date: _____

ORTHOCARE
PHYSICAL THERAPY CENTER

DIRECT ACCESS PATIENT ATTESTATION AND MEDICAL RELEASE FORM

PATIENT INFORMATION

Date

Name (Full Legal Name) | **( ) Primary Phone Number**

Street address, City, ST, ZIP Code | **( ) Alternate Phone Number**

Email address | **( ) Alternate Phone Number**

Reason why you are seeking physical therapy care:

CURRENT CARE AND ATTESTATION

Please check one below:

☐ I **AM NOT** under the care of a licensed health practitioner for the symptoms listed on this form and I wish to seek physical therapy care at this time. (Licensed health practitioner includes a doctor of medicine, osteopathy, chiropractic, podiatry, dental surgery, licensed nurse practitioner, or licensed physician assistant.)

☐ I **AM** under the care of a licensed health practitioner for the symptoms listed on this form and wish to seek physical therapy care at this time. (Licensed health practitioner includes a doctor of medicine, osteopathy, chiropractic, podiatry, dental surgery, licensed nurse practitioner, or licensed physician assistant.)

PRACTITIONER INFORMATION:

Practitioner Name | **Office Number**

Street address, City, ST, ZIP Code | **Fax Number**

I understand that the practitioner named above will be provided a copy of my initial evaluation and patient history within 14 days. ***I hereby consent to the release of my personal health and treatment records to the practitioner named above.***

Patient Signature **Date**

ORTHOCARE
PHYSICAL THERAPY CENTER

Technology Consent Form for Use of Comprehend PT Inc. AI Medical Scribe

Patient Name: _____
Date: _____

At Orthocare PT Center, we use Comprehend PT Inc.'s AI medical scribe technology to help our clinicians document your care more efficiently and accurately. Comprehend Health is a HIPAA-compliant service designed to improve clinical documentation in real-time, while ensuring your privacy and confidentiality.

How It Works:

- During your visit, your clinician may use Comprehend PT to assist with documenting the session.
- The AI listens to the conversation and generates clinical notes, helping your clinician create more accurate records.
- **Audio is not retained after processing.** Once the system has processed the recording for note-taking, the audio is permanently deleted and cannot be retrieved or accessed by anyone, including the clinic and Comprehend PT Inc.
- Your information is **not used** to train artificial intelligence models or for any purpose other than generating your clinical documentation.
- The purpose of this tool is solely to assist clinicians in improving your care and documentation efficiency and quality.

Your Privacy and Rights:

- Comprehend PT is fully compliant with the Health Insurance Portability and Accountability Act (HIPAA), meaning your privacy and personal health information are protected in accordance with HIPAA and applicable privacy laws.
- The use of Comprehend PT will in no way affect the quality of care you receive, nor does it allow your information to be shared or stored outside of your medical record.
- You have the right to ask questions or decline the use of this technology at any time during your care.

By signing below, you acknowledge that you have been informed about the use of Comprehend PT's AI medical scribe technology during your visits and consent to its use as part of your care. You understand that no recordings are stored and that the technology is used solely for documentation purposes.

Patient Signature: _____
Date: _____
Clinician Signature: _____
Date: _____