Registration Form

Sutherland Physical Therapy
5108 Northwind Blvd.
Valdosta, GA 31605
Phone: 229.244.1201
Fax: 229.244.1207

Today's date: Referring Physician:

PATIENT INFORMATION

Patient's Last Name: First: Middle: ❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No If not, what is your legal name? Birth date: / / Age:

Sex: ❑ M ❑ F Gender: ❑ M ❑ F Pronouns: ❑ She/Her ❑ He/Him ❑ They/Them

Social Security no.: Home no.: ( ) Cell no.: ( )

Street Address (P.O. Box): City: State: ZIP Code:

Occupation: Employer: Work phone no.: ( )

EMAIL ADDRESS:

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: Birth date: / / Address (if different): Primary phone no.: ( )

Relationship to patient: ❑ Self ❑ Spouse ❑ Parent/Guardian ❑ Other_____

Employer: Employer address: Work phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Primary Insurance: Subscriber's name:

Subscriber's S.S. no.: Birth date: / / Policy no.: Group no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Secondary Insurance: Subscriber's name:

Subscriber's S.S. no.: Birth date: / / Policy no.: Group no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other _____

IN CASE OF EMERGENCY

Name of friend or relative: Relationship to patient: Primary phone no.: ( ) Secondary phone no.: ( )

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

Patient/Guardian signature: _____ *Date:* _____

Cancelation / No-show Policy

Dear Patient,

We understand that periodically you may have to cancel or reschedule your appointment. In the event that you are unable to make your scheduled appointment, please contact our office as soon as possible to cancel or reschedule. It is likely that another patient is waiting for a cancelation in order to receive treatment; therefore, please give us 24 hours notice if you are unable to make your appointment.

Three or more cancelations without 24 hour notice and/or "no-shows" in a one month period will result in a charge to your account of **$25.00**.

_____ _____
Patient Name DOB:

_____ _____
Patient/Guardian Signature Date

_____
Name if signing on behalf of patient

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Informed Consent for Physical Therapy Care

Physical therapy is the evaluation or treatment of a person by the use of the effective properties of physical measures and heat, cold, light, water, electricity, sound, and air; and the use of therapeutic massage, therapeutic exercise, mobilization, and the rehabilitative procedures with or without assistive devices for the purposes of preventing, correcting, or alleviating a physical or mental disability, or promoting physical fitness and well-being.

Patient Rights

- All persons who seek physical therapy care have the right to service regardless of age, gender, race, nationality, religion or politics.
- Clients have the right to refuse physical therapy services.
- Clients have the right to privacy, confidentiality, self-determination including participation in decisions about care, cease therapy, and access to second opinion.
- Expect that the physical therapist shall provide consultation, evaluation, treatment, and preventative care in accordance with the laws and regulations of Georgia.

Patient Responsibilities

- Provide your clinician complete and accurate health and insurance information concerning illness, hospitalizations, allergies and function
- Request additional information when you do not understand
- Inform your clinician if you anticipate problems complying with the treatment plan
- Demonstrate respect and consideration for other patients and facility staff
- Notify your clinician of any changes in your condition

I hereby request and consent to the performance of physical therapy procedures. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.
I have read the above consent. I have also had the opportunity to ask questions about its consent, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature: _____ **Date:** _____
(or Signature of Legal Guardian)

Sutherland Physical Therapy, Inc.

5108 Northwind Blvd., Valdosta, GA, 31605
Ph: (229) 244-1201 - Fax: (229) 244-1207
Email: admin@sutherlandpt.com

Eric Sutherland, DPT, COMT, CSCS Michelle Sutherland, DPT, PCS, CSCS

HIPAA Privacy Compliance
Acknowledgement of Receipt of Notice of Privacy Practices

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA's Privacy Rule requires that providers with a direct treatment relationship make a good faith effort to obtain an individual's written acknowledgment of receipt of the Notice of Privacy Practices.

Privacy Standard/Rule (HIPAA)

The Privacy Rule sets the standards for how protected health information (PHI) "in any form or medium" should be controlled. This Rule took effect in April 2003 for large entities, and a year later for small ones.

Privacy Rule protections extend to every patient whose information is collected, used or disclosed by covered entities. It imposes responsibilities on the entire workforce of a covered entity -- including all employees and volunteers -- in order to secure those rights. It also requires contractual assurances for any business associates of health care institutions that handle health care information on a covered entity's behalf.

Our Notice of Privacy Practice provides information about how we may use and disclose protected health information about you. It explains how we may use it for the purpose of treatment, payment of treatment, and as required/ permitted by law. The notice may be subject to change or revision. If changes or any revisions are made to our notice, you may obtain a revised notice by request.

By signing below, you acknowledge that you were provided a copy of the notice *upon request* on the date indicated below.

Patient Name: _____

Patient/ Responsible Party Signature: _____

Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ○ Individual refused to sign
- ○ Communications barriers prohibited obtaining the acknowledgement
- ○ An emergency situation prevented us from obtaining acknowledgement
- ○ Other (Please Specify) _____

Employee Signature: _____ Date: _____

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Medical Information Release Form
(HIPAA Release Form)

Release of Information

Privacy Standard/Rule (HIPAA)

The HIPAA Privacy Rule permits covered entities to share information that is directly relevant to the involvement of a spouse, family members, friends or other persons identified by a patient, in the patient's care or payment for healthcare. If the patient is present, or is available prior to disclosure, and has the capacity to make health care decisions, the covered entity may discuss this information with the family and other persons if the patient agrees or, when given the opportunity, does not object.

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Patient Name: _____

Patient/Responsible Party Signature: _____

Date: _____

Sutherland Physical Therapy

PATIENT MEDICAL HISTORY

Name:_____ Date:_____

Reason for Visit/Chief Complaint:_____

Height:_____ Weight:_____

Medical Conditions

Diabetes: ___Yes ___No **Depression: ___Yes ___No**

Dementia: ___Yes ___No **Bipolar Disorder: ___Yes ___No**

Tobacco User*: ___Yes ___No

*If Yes, have you received counsel related to stopping tobacco usage? __Yes __No

Falls: ___Yes ___No If so, please provide dates:_____

List any medical conditions that you have (asthma, hypertension, high cholesterol, cancer history, etc.)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Current Medications: Do you take any medications? ___Yes ___No (Include vitamins, asprin, Tylenol, Ibuprofen, supplements, birth control, topical creams, etc.)

Name of Medication & Strength How Often you Take It

_____ ___Daily ___Weekly ___Monthly ___As Needed _____Other

_____ ___Daily ___Weekly ___Monthly ___As Needed _____Other

_____ ___Daily ___Weekly ___Monthly ___As Needed _____Other

_____ ___Daily ___Weekly ___Monthly ___As Needed _____Other

_____ ___Daily ___Weekly ___Monthly ___As Needed _____Other

Surgical History (Include: C-Sections, Tonsillectomy, Gallbladder, oral, etc.)

Date of Surgery: Type of Surgery:

_____ _____

_____ _____

_____ _____

_____ _____

Name:_____ **Date:** _____

Numerical Rating Scale (NRS)

Please circle the number which describes your pain now, at its worst, and at its best on the scales below. (Zero being no pain and ten being the worst pain you can imagine.)

Pain Now:

No Pain	0	1	2	3	4	5	6	7	8	9	10	**Worst Pain I can Imagine**
	Circle one number from 0 to 10											

Within the last 48-72 hours:

Pain at its WORST:

No Pain	0	1	2	3	4	5	6	7	8	9	10	**Worst Pain I can Imagine**
	Circle one number from 0 to 10											

Pain its LEAST:

No Pain	0	1	2	3	4	5	6	7	8	9	10	**Worst Pain I can Imagine**
	Circle one number from 0 to 10											

Please mark your pain on the image below: