REZAC & ASSOCIATES
PHYSICAL THERAPY, LLC
YOU make the CHOICE

855 Citadel Drive East
Colorado Springs, CO 80909
Ph: (719) 465-1502
Fax: (719) 465-2087
rezacpt.com

Patient Registration Update

Name: *(Last, First, M.I.)*			☐ M ☐ F	**DOB:**			
Address:	**Street:**						
	City:		**State:**		**Zip:**		
Phone (Check Preferred):	☐ **Home:**		☐ **Work:**		☐ **Cell:**		
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed						
Emergency Contact:			**Phone:**				
Work Status:	☐ Full-Time Employed ☐ Part-Time Employed ☐ Not Employed ☐ Retired ☐ Full Duty ☐ Light / Modified Duty ☐ No Duty / Medical Leave ☐ Student						
Job Title:		**Employer:**					
Referring Doctor:		**Primary Care Physician:**					
Other Healthcare Providers:							
Was this a work injury?	☐ Yes ☐ No	**Was this due to an accident?**	☐ Yes ☐ No				
If the accident was auto-related, what was the date of the accident & what state did it occur in?		**Date of Accident:**		**State:**			
Do you have an attorney involved?	☐ Yes ☐ No	**Attorney Name:**					
If you are a Medicare patient, are you <u>currently</u> receiving home health care?	☐ Yes ☐ No						
If you are a Medicare patient, are you <u>currently</u> receiving physical therapy at any other location?	☐ Yes ☐ No						

Patient Health History Update

Height:		**Weight:**	

List your prescription medications, over-the-counter medications, and herbals/vitamins/nutritional supplements

Name of Medication	Dosage	Frequency Taken	Route of Administration (ie: oral, topical, inhaled, etc)

Medications (continued)			
Name of Medication	**Dosage**	**Frequency Taken**	**Route of Administration (ie: oral, topical, inhaled, etc)**

List any new medical problems or surgeries since you were last seen at our office	
If you are a Medicare patient, have you had any falls in the past 12 months?	☐ **Yes** ☐ **No**
If Yes, please describe the nature of the fall(s):	
If Yes, please describe if any injury(ies) occurred:	

I certify that the above history is true to the best of my knowledge:

Signature: _____ **Date:** _____
(check one) ☐ Patient ☐ Legal Guardian (minor child) ☐ Medical Power of Attorney (must provide proof)

REZAC & ASSOCIATES
PHYSICAL THERAPY, LLC
YOU make the CHOICE

REZAC & ASSOCIATES
PHYSICAL THERAPY, LLC
YOU make the CHOICE

855 Citadel Drive East
Colorado Springs, CO 80909
Ph: (719) 465-1502
Fax: (719) 465-2087
rezacpt.com

Patient Current Condition

Please answer the following in relation to the condition for which you are CURRENTLY coming to therapy
All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: _____DOB:_____

Condition Information

Reason for this visit: _____

_____

Diagnosis from your doctor:_____

Who referred you for this episode of care? _____

Has your doctor explained to you your diagnosis & prognosis? ☐ Yes ☐ No

Was this an injury? ☐ YES ☐ NO Date of Injury or Symptom Onset: _____

Describe injury or onset of symptoms: _____

_____

Any recent change in activity level or type (work, household, recreational)? ☐ Yes ☐ No

If yes, describe :_____

Since onset / injury, have your symptoms: ☐ Improved ☐ Worsened ☐ No Change

Have you had any surgeries for this condition or for this body part?

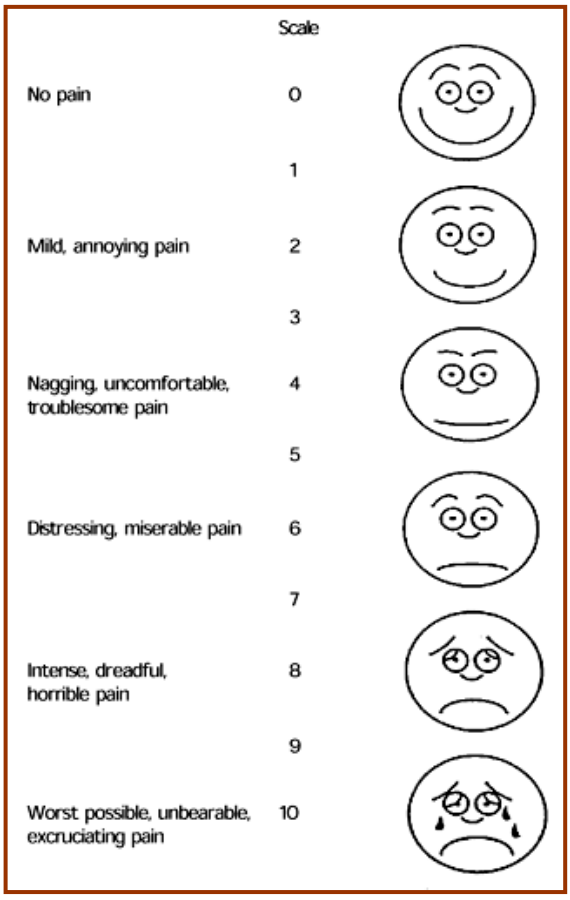
Type of Surgery	Surgeon	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any of the following for this condition? (check all that apply)

	Outcome / Result	Dates
☐ Physical Therapy	_____	_____
☐ Chiropractic	_____	_____
☐ Massage Therapy	_____	_____
☐ Acupuncture	_____	_____
☐ X-Ray	_____	_____
☐ MRI	_____	_____
☐ CT Scan	_____	_____
☐ Bone Scan	_____	_____
☐ Nerve Conduction	_____	_____
☐ Other	_____	_____

Pain Information

Rate your pain using the following scale: At Rest: _____ Best:_____ Worst:_____



What increases your pain? _____

_____

_____

What decreases your pain? _____

_____

_____

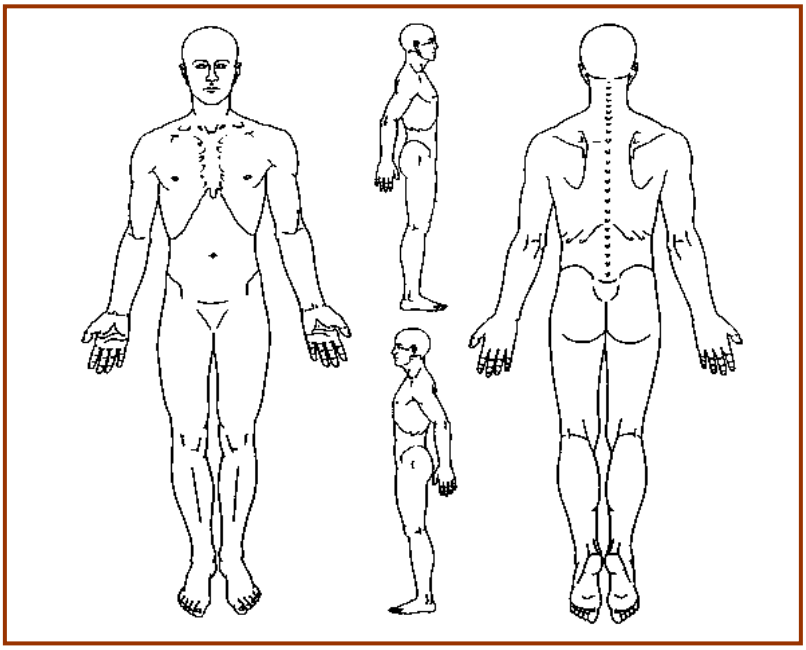
Describe your pain: _____

_____

_____

Indicate where you have symptoms on the diagram:

XX – Pain /// - Tingling or Burning ## - Numbness



Activity Information

What activities are you restricted from by your condition? (check all that apply)

☐ Dressing	☐ Bathing	☐ Eating	☐ Driving	☐ Housework	☐ Sleeping
☐ Walking	☐ Lifting	☐ Sitting	☐ Standing	☐ Lying Down	☐ Recreational
☐ Pushing	☐ Pulling	☐ School	☐ Work	☐ Sports	☐ Yard Work

Please provide details of specific activities you are restricted from doing:_____

_____

_____

_____

Work Information

I am currently: ☐ Employed Full Duty ☐ Employed with Restrictions ☐ On Medical Leave
☐ Not Employed AND ☐ Not Seeking Employment ☐ Seeking Employment

Job Title: _____
Duties: _____
Restrictions:_____

Physical Follow-Up

Next scheduled Doctor appointment(s):
Date _____ **Physician** _____
Date _____ **Physician** _____
Date _____ **Physician** _____

We are committed to a team approach to your care. Please inform your therapist whenever you have a scheduled appointment so we may send a progress note before your visit.

Physical Therapy Goals & Commitment

What do you WANT TO achieve from having therapy? Check all that apply:

☐ Improve home activities **☐ Improve mobility/walking activities**
☐ Improve leisure/sports activities **☐ Improve health/wellness**
☐ Improve self care activities **☐ Return to work/regular work duties**

What is your goal for therapy?_____
_____

Please include any additional information you feel would help us provide your care
(ie. any apprehensions about treatment, special communication, language, spiritual or cultural needs).
_____
_____
_____
_____

Will you have any problems attending therapy sessions? ☐ Yes ☐ No
If yes, please describe:_____
Will you have any problems performing a home program? ☐ Yes ☐ No
If yes, please describe:_____

I agree to be committed to my physical therapy program including attendance at scheduled visits and compliance with home program. I will inform my therapist if at any time I am unclear on my program or progress. I certify that the above history is true to the best of my knowledge:

Signature: _____ **Date:** _____
(check one) ☐ Patient ☐ Legal Guardian (minor child) ☐ Medical Power of Attorney (must provide proof)

REZAC & ASSOCIATES
PHYSICAL THERAPY, LLC
YOU make the CHOICE

REZAC & ASSOCIATES
PHYSICAL THERAPY, LLC

855 Citadel Drive E
Colorado Springs, CO 80909
(719) 465-1502

Cancellation/Missed Appointment Policy

While we understand situations may arise that prevent you from making your scheduled appointment, please remember that your appointment time is valuable and has been specifically reserved for you. Last-minute cancellations and missed appointments are costly to our practice and take up appointment slots that could be offered to other patients waiting to get in. Therefore, out of respect for the physical therapists, staff, and other patients, we ask that you provide **24-hours notice** when cancelling or rescheduling an appointment.

For a cancellation or reschedule to count as 24-hours notice, we ask that if you have an AM appointment you contact our office in the AM the day before to cancel. If you have a PM appointment, please contact our office by 7PM the day before to cancel or reschedule. If you have a Monday appointment or an appointment that follows an office closure, we will accept cancellation requests left on our voicemail if they follow the same rules above.

Unlike many other medical offices, we elect not to charge cancellation fees. We recognize extenuating circumstances such as illness, weather, unplanned emergencies, etc. may arise, as those same circumstances affect our staff, and we may occasionally have to cancel your appointments without 24-hours notice too. However, if you miss and/or cancel or reschedule three appointments without 24-hours notice, we reserve the right to reduce the number of appointments you are allowed to schedule or terminate your care at our facility.

If you arrive late to a scheduled appointment and we cannot accommodate you, you will be rescheduled. Every effort will be made to accommodate you, but we are a hands-on facility and need individual time with every patient. Whenever possible, please call to let us know you will be arriving late so that we can better plan our patient care and more easily accommodate you. If late arrivals become a chronic issue, we reserve the right to reduce the number of appointments you are allowed to schedule or terminate your care at our facility.

A large part of the success of physical therapy is your participation. If you frequently cancel, arrive late, and do not show for appointments, your likelihood of improvement is significantly decreased. While we understand special circumstances, if it is a chronic issue we will evaluate whether physical therapy is appropriate for you at this time.

I have read the above information and/or it has been explained to me and I accept the terms and conditions of the above.

Signature _____ Date _____

REZAC & ASSOCIATES
PHYSICAL THERAPY, LLC

855 Citadel Drive East
Colorado Springs, CO 80909
(719)465-1502

Rezac & Associates Physical Therapy, PLLC will at times need to contact you. By filling out the information below we will be better able to serve.

PHONE MESSAGE CONSENT

☐ I authorize Rezac & Associates Physical Therapy, PLLC to leave phone messages regarding my appointments, medical care and/or billing. My preferred phone number(s) are: _____
_____

☐ I authorize Rezac & Associates Physical Therapy, PLLC to discuss my appointments, medical care, and/or billing with following individuals (i.e. family members, caregivers, etc): _____
_____

EMAIL & TEXT MESSAGE APPOINTMENT REMINDER CONSENT

Rezac & Associates Physical Therapy, PLLC can send reminders via email and/or text message to remind you of the day and time of scheduled appointments. If you would like to receive appointment reminders, please select from the options below:

☐ I authorize Rezac & Associates Physical Therapy, PLLC to send me appointment reminders via email. My email is: _____.

☐ I authorize Rezac & Associates Physical Therapy, PLLC to send me appointment reminders via text message. I understand that standard text message rates from my wireless carrier may apply. My phone number is: _____.

NEWSLETTER SIGN-UP

Rezac & Associates Physical Therapy, PLLC offers a monthly Health and Wellness video newsletter. If you would like to subscribe, please check the box below.

☐ I authorize Rezac & Associates Physical Therapy, PLLC to add me to their Video Newsletter.
Email Address: _____

By signing below, I fully understand that the consents listed above will remain valid until revoked in writing.

Signature: _____ Date: _____

REZAC & ASSOCIATES
PHYSICAL THERAPY, LLC

855 Citadel Drive East
Colorado Springs, CO 80909
(719)465-1502

Consent for Care and Treatment

I, the undersigned, do herby agree and give my consent for Rezac & Associates Physical Therapy to furnish medical care and treatment to _____ which is considered necessary and proper in the diagnosing or treating of my (his/her) physical condition.

Signature:_____ Date:_____

Benefit Assignment/ Release of Information

I, the undersigned, herby assign all medical benefits, i.e.: Medicare, private insurance, major medical benefits, Workers' Compensation and any other health plans to which I am entitled to Rezac & Associates Physical Therapy, LLC PC. A photocopy of this consignment is to be considered as valid as the original. I hereby authorize Rezac & Associates Physical Therapy, LLC PC to release all medical information and records necessary to secure payment for services rendered.

Signature:_____ Date:_____

Financial Policy Statement

It is our policy to bill your insurance carrier or other provider of medical benefits as a courtesy to you, although you are responsible for the entire bill when the service is rendered. Required co-payments and estimated co-insurances are to be paid as services are rendered and arrangements are to be made for payment of all amounts not covered by you medical benefits or estimated co-insurances as soon as those amounts are known. If your medical benefits are not paid within sixty (60) days, the balance will be due in full from you.

All co-insurance percentages paid at the time of service are estimated. Your actual liability may be more. You are responsible for any difference between the estimated and actual co-insurance due.

If any payments of medical benefits are made directly to you for services rendered by Rezac & Associates Physical Therapy, LLC PC, you must promptly remit such payment directly to Rezac & Associates Physical Therapy, LLC PC.

If you are a Workers' Compensation patient the above policy does not apply to you. Be advised, however, that you may be responsible for our charges if your Workers' Compensation claim is successfully controverted.

If you fail to make timely payment for any amount for which you are responsible, you will be responsible for all costs of collection, including court costs, collection agency fees and or a reasonable attorney fee.

I have read the above information and/or it has been explained to me and I accept the terms and conditions of the above and will be responsible for the payment of my account.

Signature:_____ Date:_____