REGISTRATION FORM

Village Golf & Physical Therapy

VGPT - West
100 Calella Rd, Suite A
Hot Springs Village, AR 71909
(501) 984-2453

VGPT - East
110 Este Way, Suite 3
Hot Springs Village, AR 71909
(501) 915-8478

PATIENT INFORMATION

Today's Date	❑ Auto ❑ Workers Comp ❑ Other	Area To Be Treated:	
Last Name	First Name, Middle Initial		
Street Address	Town	State	Zip Code
Phone #	Email	Date Of Birth	Gender ❑Male ❑ Female
Primary Care Physician Name	Phone #	Have You Had Physical Therapy Before? ❑ Yes ❑ No	
Referring Physician Name	Phone #	If Yes, When:	
Emergency Contact Name	Relation	Phone #	
Employer Name	Phone #		
Parent/Guardian Name	Relation	Phone #	
Are you currently, or have you recently had home health services? ❑ Yes ❑ No	If yes, are you still receiving service? ❑ Yes ❑ No If no, when were you discharged?		
Who can we thank for the referral?			

HEALTH STATUS FORM
Village Golf & Physical Therapy

HEALTH STATUS

Last Name, First Name (Printed):

Present Complaint:

Date of Onset:

How did the injury occur? Check all that apply:
❑ Accident ❑ Fall ❑ Gradually ❑ Work Injury ❑ Lifting ❑ Surgery ❑ Other_____

Do you have pain?
❑ Yes ❑ No

Rate Pain (0 no pain - 10 high pain) At best:_____ At worst: _____

Have you had physical therapy for this problem before? ❑ Yes ❑ No

If yes, when?

What tests have been done? ❑ CT Scan ❑ MRI ❑ X Ray ❑ EMG ❑ Bone Scan ❑ Ultrasound ❑ None

PAST MEDICAL HISTORY

If yes, please provide details:

High Cholesterol	❑ Yes ❑ No _____	Pregnant	❑ Yes ❑ No _____
High Blood Pressure	❑ Yes ❑ No _____	Stroke	❑ Yes ❑ No _____
Heart Problems	❑ Yes ❑ No _____	Blood Clots	❑ Yes ❑ No _____
Seizures/Neurological	❑ Yes ❑ No _____	Pacemaker	❑ Yes ❑ No _____
Behavioral/Learning	❑ Yes ❑ No _____	Cancer/Tumor	❑ Yes ❑ No _____
Anxiety/Depression	❑ Yes ❑ No _____	Diabetes	❑ Yes ❑ No _____
Genetic/Congenital	❑ Yes ❑ No _____	Bloodborne Pathogens	❑ Yes ❑ No _____
Bone Joint Problems	❑ Yes ❑ No _____	Asthma/COPD	❑ Yes ❑ No _____
Do you smoke?	❑ Yes ❑ No _____		

Other (describe):
_____

Significant Past Surgeries:
_____

Do you have a history of falls? Yes _____ No _____ If yes, when was your most recent fall? _____
What were you doing at the time of the fall?
_____

Required for Insurance Purposes: Height _____ Weight _____

MEDICATIONS AND ALLERGIES

List all medications, prescriptions, OTC Medication and vitamins including dosage and method (a separate typed or handwritten list of current medications is also acceptable):
_____
_____
_____

List all food and medical allergies (including latex & adhesives):
_____

Signature: _____ Date:_____

PATIENT AUTHORIZATION AND GUARANTEE

Village Golf & Physical Therapy

CONSENT OF TREATMENT

I hereby consent to all treatment procedures and patient care deemed necessary by my physical therapist while I am a patient of Village Golf & Physical Therapy.

PAYMENT AUTHORIZATION

I hereby authorize that the payment of authorized benefits be made directly to Village Golf & Physical Therapy for any services that are reimbursable by Medicare or any third party source. I understand that I am responsible for any health insurance deductible and co-insurance.

HIPAA REGULATIONS

I understand that Village Golf & Physical Therapy complies with HIPAA and will use it as allowed by law in the treatment, billing and collection pertaining to my care. I also authorize the release of any information pertinent to my case to any insurance company, or adjuster securing payment under this policy of insurance or to my medical provider associated with my case to effectively treat me.

CANCELLATION POLICY

While we expect you to keep all of your appointments, we recognize there may be a time when you need to cancel. **We require 24 business hour notice if you need to cancel so we can fill your appointment time. If you do not give a 24 business hour notice, or you no-show for an appointment a $50.00 fee will be billed to you and due on your next visit.**

Home Health Care

_____Yes_____ No____ Are you currently receiving any form of home health care service?

PATIENT RESPONSIBILITY

As a courtesy, your insurance benefits were verified. You are responsible to know your benefits. We expect copay/ coinsurance/deductible at the time of your visit.

Deductible: _____ Met: _____ Remaining: _____

Copay: _____ Coinsurance: _____ Visits: _____ Pre-Auth: Yes _____ No _____

Advantage Plan: Yes _____ No _____ Result of an Accident: Yes _____ No _____

Referring Physician: _____

I _____ have read and understand all guarantees and financial policies above.

Signature _____ **Date_____**

Witness Signature _____ **Date_____**