18101 R Plaza, Ste 106
Omaha, NE 68135

(402) 933-8333
(402) 933-4755 fax

Patient Demographics:

Name: ____________________________ Marital Status: Single-Married-Other Age: _____ DOB: ________ Gender: Male/Female

Address: __________________________ City: ______________ State: ______ Zip Code: ________ SSN: ____________________

Primary Phone Number: __________________ Voicemail Y/N Preferred Contact Y/N Cell Phone Number: ___________________ Voicemail: Y/N Preferred Contact Y/N

Employer: ______________________________ Work Phone Number: ______________________ Voicemail: Y/N

Address: __________________________ City: ______________ State: ______ Zip Code: ________ Occupation: _________________

Employment Status: Employed-Self Employed-Retired-Disabled-Student Email: ______________________________ Contact: Y/N

Emergency Contact:

Name: ______________________________ Phone Number: ______________________ Relationship: ______________

Insurance Information:

Primary Insurance: ______________________ Group No: ____________ ID#: ___________________________________

Primary Insured Name: ____________________________ DOB: _____________ SSN: _________________ Relationship: _____________

Secondary Insurance: ______________________ Group No: ____________ ID#: ___________________________________

Primary Insured Name: ____________________________ DOB: _____________ SSN: _________________ Relationship: _____________

Billing/Parent

Name: ______________________ Address: __________________________ City: ______________ State: ______ Zip Code: ________

Relationship: ____________________ DOB: _____________ SSN: _________________ Phone Number: _________________

For Minor Child: Custody Status: Mother/Father/Joint

Health:

Work Related Injury: Y/N Date of Injury: _______________ Contact Name: ____________________ Phone Number: ______________

Motor Vehicle Accident: Y/N Date of Injury: _____________ Contact Name: ____________________ Phone Number: _____________

Referring Physician: ____________________ Date of Last Visit: ____________________ Date of Injury/Onset of Symptoms: __________

Consent for treatment: I hereby give my consent to receive treatment and authorization to release payment and information. I request that payment of authorized Insurance benefits be made either to me or on my behalf to Go Physical Therapy, P.C., for any service furnished by this provider employed by same. I authorize any holder of medical information about me to release to my insurance carrier and its agents any information needed to determine these benefits or the benefits payable for related services. As a service to you, our office will bill all insurance. However, you are responsible for payment of your balance. Payment can be made at any time to our office. If you do not have any insurance, payment is expected at time of service. I understand that my diagnosis and treatment plan will be discussed during my appointment and that I have the right to question and/or refuse any treatment offered.

Signature ____ ***Date*** ___________________________

If you are 18 years or younger, a parent or guardian must sign this patient registration form on your behalf.

GO Physical Therapy Patient Questionnaire

Do you have any barriers to learning? Yes/No If "Yes", please list: ____

Past Surgical History: (list & date) ____

What medications are you taking now? (Include prescription, over-the-counter drugs, supplements such as vitamins, and herbals.)

Medication Name	Dosage	Frequency	Route of administration (ie: oral, injection)
________________________________	____________________	_________________	____________________________________
________________________________	____________________	_________________	____________________________________
________________________________	____________________	_________________	____________________________________
________________________________	____________________	_________________	____________________________________
________________________________	____________________	_________________	____________________________________

Gender: M/F Age: __________ Height: ___________ Weight: ______________

Occupation: ______________________________ Smoker: Y/N Pregnant: Y/N

Do you exercise at least 3 days per week? Y/N

Past Medical History: ***Please circle each condition that you have been told you have (or had):***

Alzheimer's | Cardiovascular Disease | Cauda Equina Syndrome | Cerebral Vascular Accident | Immunosuppression
Diabetes | Fibromylagia | High Blood Pressure | History of Cancer | Huntington's
Lupus | Obesity | Osteoarthritis | Parkinson's | Traumatic Brain Injury
Sexually Transmitted Disease | Allergies/Asthma | Muscular Dystrophy

Have you had a recent illness: ______________________________ Other: ____

Do you take blood thinners? Y/N Are you allergic to latex? Y/N

Currently, I am experiencing (circle all that apply):

Fever/chills/sweats Unexplained weight loss/gain Change in appetite Changes in bowel or bladder function
Difficulty swallowing Depression Dizziness Shortness of breath Headaches Nausea/Vomiting

____

Have you fallen in the last year? Y/N If yes, how many times in the last year?________ Poor Balance: Y/N

If you have fallen in the last year, were you injured? Y/N If yes, please explain:____

How are you able to sleep at night? ☐ Fine ☐ Moderate Difficulty ☐ Only with medication

During the past month, have you often been bothered by feeling down, depressed, or hopeless? Y/N

During the past month, have you often been bothered by little interest or pleasure doing things? Y/N

Date of Surgery: __________________________ Have you had an x-ray, MRI, or other imaging study for this problem? Y/N

What date (approximately) did your present pain start? ____________________ Describe your condition (circle one): Chronic / Insidious / New injury

My symptoms are currently (circle one): Getting better / About the same / Getting worse

What treatment have you received for this problem so far? ____

What makes your symptoms better? ____________________________________What makes your symptoms worse? _______________________________

Pain Description (circle the one that applies):

Burning Sharp Dull/Achy Throbbing Shooting Numbness Tingling Constant Intermittent
Worse in AM Worse in PM Worse at night

Please circle the number which best represents the average level of pain you have experienced:

At Worst:	No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain imaginable
Currently:	No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain imaginable
At Best:	No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain imaginable

What are your personal goals for Physical Therapy at this time? ____

PAYMENT POLICY FORM

PATIENT NAME: ________________________

Please check the appropriate payment method:

______ PRIMARY INSURANCE: **We will bill your primary insurance as a courtesy to you. We assume payment of insurance benefits not forthcoming on charges older than 60 days. Charges outstanding for more than 60 days will be due in full from you regardless of the type of insurance involved. Any remaining balance after your co-pay and your primary coverage has been paid, including items classified as "above usual and customary" is due from you upon receipt of the explanation of benefits from your primary insurance carrier. You will be responsible for any item not paid in full by your insurance provider. Prior to beginning treatment, we will verify any insurance benefits. While we take all reasonable action to provide accurate physical therapy benefit information for your specific plan, be aware that verification is not a guarantee of payment from your insurance carrier. Secondary insurance will be your responsibility to file and collect.**

____ MEDICARE: **We will bill Medicare for you. In most cases Medicare will pay 80% of allowable charges. We will bill your secondary insurance for you, if you have one, or the balance will be billed to you.**

____ SELF-PAY **Please pay the balance in full at the time of service or upon the receipt of a monthly statement or notice. In the event you are unable to pay the balance in full, we are willing to make reasonable payment arrangements. Please be advised that Go Physical Therapy, P.C. is not a credit grantor, and therefore, failure to maintain these arrangements may result in the placement of your account with a collection agency or attorney for collection. Credit cards (MasterCard, Visa and American Express) are accepted for payment on account.**

____ WORKERS'COMP: **We will bill your Workers' Comp carrier for your charges. Please note that you will remain financially responsible for all of your charges if your carrier denies coverage.**

____ LEGAL SUIT: **We will accept a legal letter of protection if you meet each of the following criteria:**

1. **Do not qualify for benefits under any insurance policy (medical or auto), and**
2. **Are indigent and cannot pay for charges due using cash or credit card, and**
3. **Are awaiting settlement and subsequent payment of damages from a related legal case, and**
4. **Return our lien, signed by both you and your attorney.**

Prior to your settlement, payment on your account will not be required unless your charges remain outstanding for more than 90 days from the date of last treatment. Upon settlement of your legal case, your balance is in full is due within 30 days. Please be aware that you will remain financially responsible for services rendered regardless of the payment option selected above.

In the event your account becomes delinquent and is therefore in default of payment, the patient, legal guardian, or admitting parent will be responsible for the principle amount owed, and all reasonable costs associated with the collection of this debt, including, but not limited to, collection service fees, attorneys' fees, and all the court costs and additional legal expenses associated with the recovery of this debt. We reserve the right to charge interest on balances over 30 days old, charge return check fees as allowed by state law.

Thank you for allowing us to serve you. If you have any questions about the above information or any uncertainty regarding your insurance coverage, please ask for our assistance. Kindly sign and date this document to indicate that you understand and agree to the terms of this payment policy.

□ **Checking this box indicates that the formal office HIPAA policy and procedures have been explained to the above-noted patient and that a copy of the policy was provided to the patient. (See next 2 pages)**

Consent for assignment of benefits and authorization to release medical information:

I hereby assign all medical benefits to which I am entitled to Go Physical Therapy, P.C. in the event they file insurance on my behalf: I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principle amount owed as well as all reasonable costs associated with the collection of this debt.
This includes but is not limited to the collection service fees, and all court costs and additional legal fees associated with the recovery of this debt. Interest may be charged at the rate of 1.5% per month (12% annually) for unpaid balances over 30 days old. A copy of this assignment shall be considered as effective and valid as the original.

I do hereby consent to such treatment by the authorized personnel of Go Physical Therapy, P.C., as may be dictated by prudent medical practice by my illness, injury or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

AUTHORIZED SIGNATURE: ______________________________ DATE: __________________________

NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW MEDICAL AND PERSONAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS FORM CAREFULLY

OUR LEGAL DUTY

Go Physical Therapy, P.C., is required by law to protect the privacy of your personal and health information, provide notice about our information management practices, and follow the information protocols described below.

USAGES AND DISCLOSURES OF HEALTH INFORMATION

Go Physical Therapy, P.C., uses your personal and health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and assessing the quality of care we are proud to provide. We use your personal information to contact you to arrange an appointment with us and to properly bill your insurance carrier for the services we provide you. In addition, we may, from time to time, disclose your health information without prior authorization for public health purposes, auditing, tracking, and research studies.
In any other situation, Go Physical Therapy, P.C., will obtain your written permission and authorization before disclosing your personal health information. If you provide us with written authorization to release your information for any reason, you may later revoke that authorization to cease further disclosures at any time. If and when any changes are made in our privacy and confidentiality policies, a new Notice of Information Practices will be posted in the same area for public view. You may request a copy of our Notice of Information Practices at any time. Our HIPAA Compliance Officer is Brian L. Brunken. He may be reached at the office by calling (402) 933-8333.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct inaccurate or incomplete information in your records. You also have a right to request a list of instances where we disclosed your personal health information for any reasons other than for treatment, payment, or other related administrative purposes.
You may request in writing that we not use or disclose your personal health information for treatment, payment, or administrative purposes except when specifically authorized by you, when required by law, or in an emergency. Go Physical Therapy, P.C., will consider all such requests on a case – by - case basis. The company is not legally required to accept the requests.

CONCERNS AND COMPLAINTS

If you are concerned that Go Physical Therapy, P.C., may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our HIPAA Compliance Officer, Brian L. Brunken, P.T.,O.C.S., at the office address listed below. You may also send a written complaint to the U.S. Department of Health and Human Services.

Go Physical Therapy, P.C.
HIPAA Compliance Officer
Attention: Brian L. Brunken, P.T., O.C.S.
18101 'R' Plaza, Suite 106
Omaha, NE 68135
Phone: (402) 933-8333

Every Patient Must Receive a Copy of This Form

--tear here---

ACKNOWLEDGEMENT OF RECEIPT

Patient name ____

Signature ________________________________ **Date** ____________

Guardian Signature if under 18 ________________________________