Patient Registration

Sports Medicine Specialists dba Fit For Life Physical Therapy

Last Name __________________________ **First Name** ____________________________ **Middle Name** _______________

Preferred Name ________________________ **DOB** _______________ **Employer/School** ___________________________

Gender Identity _____________________ **Sex Assigned at Birth** __________ **Preferred Pronouns** ____________________

Home Address ________________________________ **City** __________________________ **State** _______ **Zip** __________

Cell Phone _______________________ **Home Phone** _______________________ **Work Phone** _______________________

Email Address ____

In accordance to our Patient Care Pledge, how would you like to receive appointment reminders? ☐ **Email** ☐ **Text**

Emergency Contact __________________________ **Relationship** _______________________ **Phone** _________________

How did you learn about Fit For Life? ___________________________ **Were you referred by MIT?** ☐ **Yes** ☐ **No**

Type of Injury ____ **Date of Injury** _________________________________

Cause of Injury ____

Were you referred by a Physician? ________ **If YES, Name** ____

If NO, do you have a Primary Care Physician? ________ **Name** ____

Do you wish for us to communicate with your Primary Care Physician about your care? __________________________

Consent for Care

I do hereby agree and give my consent for Sports Medicine Specialists dba Fit For Life Physical Therapy to furnish medical care and treatment considered necessary and proper in the evaluation and treatment of my physical conditions.

____

Patient/Guardian Signature **Date**

Assignment of Benefits/Release of Information

I certify that all information on this form is correct. I hereby assign all medical benefits to which I am entitled, including major medical, Medicare, Medicaid, private insurance and third party payors to Sports Medicine Specialists dba Fit For Life Physical Therapy. A photocopy of this assignment is to be considered valid as the original. I hereby authorize Sports Medicine Specialists dba Fit For Life Physical Therapy to release all information necessary, including records, to secure payment.

____

Patient/Guardian Signature **Date**

____

Facility Representative Signature **Date**

FIT FOR LIFE PHYSICAL THERAPY

Patient Medical History

Sports Medicine Specialists dba Fit For Life Physical Therapy

Last Name ___________________________ **First Name** _____________________________ **Middle Name** ________________

Have you seen a medical provider or have had any medical services for THIS injury/episode?

Medical Providers (please name):

General Practitioner ________
Orthopedist ________
Emergency Room Care ________
Urgent Care ________
Podiatrist ________
Chiropractor ________

Rehabilitative Providers (please name):

Massage Therapy ________
Occupational Therapy ________
Physical Therapy ________

Diagnostic Imaging/Tests (please date):

MRI ________
CT Scan ________
X-Rays ________
EMG ________
Myelogram ________

Other: ____

Please name any prescription and/or non-prescription medications you are currently taking:

Anti-inflammatories ________
Muscle Relaxers ________
Pain Medication ________
Antibiotics ________
Other Medications ____________________________
____

Do you NOW HAVE or HAVE YOU EVER HAD any of the following medical conditions?

Severe or Frequent Headaches ________
Vision or Hearing Difficulties ________
Asthma/Bronchitis/Emphysema ________
Shortness of Breath/Chest Pain ________
Coronary Heart Disease/Angina ________
Pacemaker ________
High Blood Pressure ________
Heart Attack or Heart Surgery ________
Stroke/TIA ________
Blood Clot/Embolism ________
Epilepsy/Seizures ________
Thyroid Trouble/Goiter ________
Anemia ________
Infectious Diseases/Covid-19 ________
Diabetes ________
Cancer or Chemotherapy/Radiation ________
Arthritis/Swollen Joints ________
Osteoporosis ________
Gout ________
Sleeping Problems/Difficulties ________
Emotional/Psychological Problems ________
Bowel or Bladder Problems ________

Skin Adhesive Allergy/Sensitivity (e.g. bandages/medical tape/k-tape) ________
Latex Allergy/Sensitivity ________
Sulfate Allergy/Sensitivity ________
Any Pins or Metal Implants ________
Joint Replacement ________
Neck Injury/Surgery ________
Shoulder Injury/Surgery ________
Elbow/Hand Injury/Surgery ________
Back Injury/Surgery ________
Knee Injury/Surgery ________
Leg/Ankle Injury/Surgery ________
Numbness or Tingling ________
Dizziness or Fainting ________
Ringing in Your Ears ________
Weakness ________
Weight Loss/Energy Loss ________
Hernia ________
Tuberculosis ________
Other Allergies/Sensitivities ________
Are you Pregnant? ________
Do you Smoke? ________

Please list any other information that would assist us in your care:

____

Based on your awareness of your diagnosis, what are your goals of rehabilitation?

____

It is the policy of Sports Medicine Specialists dba "Fit For Life Physical Therapy" for all patients to have the opportunity during the first visit to discuss the evaluation findings, the proposed Plan of Care by the Therapist, and have any and all questions answered satisfactorily prior to commencing therapy.

____

Patient/Guardian Signature **Date**

____

Treating Clinician Signature **Date**

Acknowledgement of Review of Notice of Privacy Practices

Sports Medicine Specialists dba Fit For Life Physical Therapy

Last Name __________________________ **First Name** ____________________________ **Middle Name** _______________

I have reviewed this facility's Notice of Privacy Practices, which explains how my private health information will be used and disclosed. I understand that I am entitled to receive a copy of this document. By signing this form, I consent to the use and disclosure of my protected health information for the purpose of treatment, payment and healthcare operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent. A photocopy or fax of this consent is as valid as the original.

In addition, I authorize the release of information to the **individuals, entities, coaches, athletic trainers, medical professionals not included in my referral** identified below by name and relationship:

Name: ___________________________ **Relationship:** ____________________ **Contact Info:** ____________________

Name: ___________________________ **Relationship:** ____________________ **Contact Info:** ____________________

Name: ___________________________ **Relationship:** ____________________ **Contact Info:** ____________________

Name: ___________________________ **Relationship:** ____________________ **Contact Info:** ____________________

____

Patient/Guardian Signature **Date**

____

Facility Representative Signature **Date**

For Office Use Only

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

_____________ Individual refused to sign

_____________ Communication barriers prohibited obtaining the acknowledgement

_____________ Other (Please specify) ____

Patient Care Pledge

Sports Medicine Specialists dba Fit For Life Physical Therapy

Last Name ________________________ **First Name** __________________________ **Middle Name** ______________

Fit For Life Physical Therapy is proud to participate in your care. Thank you very much for choosing to trust us for your orthopedic & sports medicine physical therapy needs.

We pledge to assist you in every way possible towards the achievement of your personal physical therapy goals and ask that you pledge to do your part as well. Please read each of these points and acknowledge that you understand & agree by signing below.

I understand that:

- ✓ Fit For Life is a small, locally-owned, family business and is not backed by a large medical system. I need to give at least 24 hours' notice for cancellations and/or rescheduling in order to give Fit For Life the opportunity to offer the appointment time to another patient who may need it. __________ Initials

- ✓ If I am not pleased with any clinical or non-clinical aspect of my care, that I can speak with the owners, Sean & Lou Ann Huffman, anytime I would like by calling 614-432-6401. They will do everything in their control to ensure that my valuable time is used well and that I am improving in all aspects of my personal plan of care. __________ Initials

- ✓ I can only improve if I do my part and attend my scheduled appointments at Fit For Life Physical Therapy. To assist me in maintaining my personal plan of care and getting to my appointments on time, I have been offered reminders via text message and/or email. __________ Initials

Acknowledged,

____

Patient/Guardian Signature **Date**

____

Facility Representative Signature **Date**