ELITE
THERAPY & WELLNESS
PHYSICAL THERAPY • CHIROPRACTIC • MASSAGE THERAPY

_____INS

Patient Registration

Name: Mrs./Ms./Mr. _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Marital Status: S M D W E-mail: _____ DOB: _____

Best phone number to reach you at: Cell/Work/Home _____

Emergency contact: _____ Emergency contact number: _____

Whom may we thank for this referral? _____

Please list previous surgeries and hospitalizations: _____

_____

Please list current medications and dosages: _____

_____

If you need to discuss these or any problems with a professional, please check here _____.

HAVE YOU HAD, BEEN DIAGNOSED AS HAVING, OR CONSULTED A PHYSICIAN FOR ANY OF THE FOLLOWING: (Please check any and all that apply)

( ) Diabetes/Hypoglycemia	( ) Heart Attack	( ) Smoke/Tobacco User
( ) High Blood Pressure	( ) Respiratory Illness _____	( ) Convulsions
( ) Cancer	( ) Multiple Sclerosis	( ) HIV/ AIDS
( ) Liver Disease	( ) Parkinson Disease	( ) Hot/Cold Intolerance
( ) Arthritis	( ) Seizures	( ) Hemophilia
( ) Alzheimer's	( ) Shingles	( ) CVA (Stroke)
( ) Osteoporosis	( ) Lupus Erythema	( ) Heat Stroke/Illness
( ) Asthma	( ) Vertigo	( ) Metal Implants _____
( ) Acute Infections	( ) Previous Head Trauma	( ) Hepatitis
( ) Allergies _____	( ) Joint Problems	( ) MRSA
( ) Latex Sensitivity	( ) Pacemaker/ Defibrillator	( ) Other: _____

Acknowledgement, Authorization, and Assignment

I have viewed a copy of Elite Therapy and Wellness Notice of Privacy Practices and it has been explained to me as required by the Health Insurance Portability and Accountability Act (HIPAA). I authorize Elite Therapy and Wellness and its agents to release any information including my protected information to any insurance company or billing company and its agents as is necessary to determine benefits. I authorize payment to be made by my insurance carrier directly to Elite Therapy and Wellness for services rendered.

+ _____ _____

Patient Signature Date Witness

Consent for Purposes of Treatment, Payment and Healthcare Operations

I hereby authorize Elite Therapy and Wellness to render therapy services. I understand an appropriate level of therapy personnel will provide such care. I recognize and agree that I have the right to refuse treatment at any time by notifying Elite Therapy and Wellness administrative or clinical staff.

In addition, Elite Therapy and Wellness may terminate services by notifying me of termination and the reason. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

Copayment Promissory Agreement

As a courtesy of our patients, Elite Therapy and Wellness will file insurance claims and make every effort to collect payment directly from your carrier. We collect only the co-payment portions of your bill at the same times services are rendered. I understand that I am also responsible for any collection charges, attorney's fees and court costs necessary to effect payment for this account.

Our insurance verification determined the following: _____ INS ID# _____GRP#_____

Your deductible of $_____ must be met before your insurance carrier will issue payment.

Your insurance carrier is paying at _____% you are responsible for approximately _____% and any unpaid/reduced claims. A _____ co-payment/balance payment is due each visit to be applied to your account. _____ OV/pcy

It is advised for you to contact your insurance carrier also for re-verification of your benefits. The above information is not a guarantee of coverage/payment from your insurance carrier.

I certify that my insurance coverage has been explained to me and that I have been advised to re-verify my benefits with my carrier. I understand that I am personally responsible for all bills unpaid by my insurance carrier.

I hereby authorize my insurance carrier to make medical benefits payments otherwise payable to me for services rendered by Elite Therapy and Wellness but not to exceed the charges of those services, payable to and mailed directly to the office.

+_____ _____

Patient Signature Date

Medical Records Release:

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me release true copies of same to Elite Therapy and Wellness or any insured providing coverage to me in connection with the processing of any claims for benefits made by me or by the assignee herein. A photocopy of this document shall be as binding as an original signature page.

Furthermore, I hereby IRREVOCABLY ASSIGN to Elite Therapy and Wellness the rights and benefits under any policy of insurance. Indemnity agreement or any other collateral as defined in Florida Statues for any services and/or charges providing Elite Therapy and Wellness.

IN WITNESS WHEREOF, I have hereunto set my hand and official attestation on this _____ day of _____, 2018.

+_____ _____

Patient Signature Patient Name (Print)

Cancelled/Missed Appointments:

Appointments are to be cancelled within 24 hours of your scheduled appointment. If you fail to keep your appointment or do not cancel prior to 24 hours, we reserve the right to charge $30.00 for missed appointments.

Your insurance company will not pay for missed appointments; therefore you will be responsible for this fee.

RockTape

If you are a candidate for RockTape please be advised; your first two applications of RockTape will be a courtesy. Any subsequent RockTape applications thereafter will be $5.00 per taping to offset our cost of the tape.

RockTape is a special kind of tape known as kinesiology tape. First used by acupuncturists and chiropractors in Japan, today kinesiology tape is used by practitioners throughout the world to treat injuries and improve sports performance. Rocktape is made from 97% cotton and 3% nylon. **The adhesive is hypo-allergenic, acrylic-based and contains no latex.**

+_____

Patient Signature

+_____

Witness

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Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

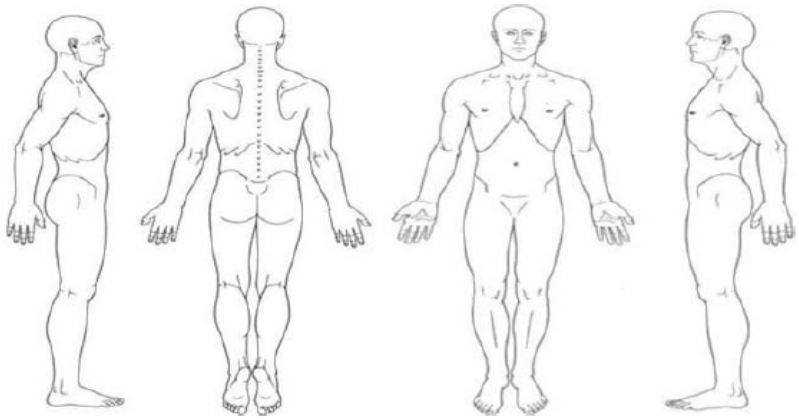
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

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8. Who have you seen for your symptoms?

① No One
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

_____

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature _____ **Date** _____