In order to make registration simple and quick, please use this checklist to make sure you have provided all necessary information and signatures. The process, including the call to your insurance company, should take no more than 15 minutes. Thank you for helping us get your therapy started quickly.

- COMPLETE THE NEW PATIENT REGISTRATION FORM (page 1), including
  - Section I, New Patient Information
  - Section II, Billing and Payment Information
- READ THE NOTICE OF PRIVACY PRACTICES (page 4)
- READ THE NOTICE OF FINANCIAL POLICIES (page 5)
- READ, INITIAL, AND SIGN section III of the registration form (page 1, Section III) where indicated
- USE THE “CALLING YOUR INSURANCE COMPANY” GUIDE (page 6), to verify your physical therapy benefits under your insurance policy (YOU DO NOT NEED TO CALL MEDICARE, MEDICAID, TRICARE, THE VETERAN’S ADMINISTRATION, OR ANY OTHER GOVERNMENT-SPONSORED PLAN)
- PHOTOCOPY YOUR INSURANCE and ID CARD(S) (front and back) and bring the copies with this packet.

Please bring these papers to your first appointment.

NORTHERN EDGE PHYSICAL THERAPY offers HELP to those who HURT

Healing Edge: We recognize the role of healing as the key element in the struggle to survive.

Expert Edge: We provide a unique client-focused experience with clinical expertise and skilled hands-on therapy as a cornerstone of clinical practice.

Leading Edge: We offer a diverse group of specialized programs to give clients opportunities to access leading edge pain-relief and life enhancement.

Professional Edge: We maintain the highest standards of quality for every aspect of client care.
# NORTHERN EDGE PHYSICAL THERAPY

## NEW PATIENT REGISTRATION FORM

<table>
<thead>
<tr>
<th>SECTION I: NEW PATIENT INFORMATION</th>
<th>ID# (OFFICE USE ONLY):</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name:</td>
<td>Middle:</td>
</tr>
<tr>
<td>Street Address:</td>
<td>City:</td>
</tr>
<tr>
<td>Home Phone:</td>
<td>Work Phone:</td>
</tr>
<tr>
<td>Emergency Contact:</td>
<td>Relationship:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SECTION II: BILLING AND PAYMENT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Health Insurance Company (if none, enter “SELF”):</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Secondary Health Insurance Company (if applicable):</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Auto, Liability, or Worker’s Compensation Insurance Company (if applicable):</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SECTION III: SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>(INITIAL) I understand that physical therapy is always voluntary, that there may be other treatment options, that there may be risks associated with therapy, and that I may request to discuss those risks with my therapist. With this understanding, I CONSENT TO RECEIVE PHYSICAL THERAPY TREATMENT at Northern Edge Physical Therapy.</td>
</tr>
<tr>
<td>(INITIAL) I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY to Northern Edge Physical Therapy, and have read and agree to the “Notice of Financial Policies,” provided by Northern Edge Physical Therapy.</td>
</tr>
<tr>
<td>(INITIAL) I HAVE BEEN INFORMED OF MY PRIVACY RIGHTS, and have read and understand the document “Health Information Privacy under HIPAA,” provided by Northern Edge Physical Therapy.</td>
</tr>
<tr>
<td>(INITIAL) I AUTHORIZE RELEASE OF ANY PERSONAL OR HEALTH INFORMATION necessary to process insurance claims or to provide and coordinate my treatment at Northern Edge Physical Therapy.</td>
</tr>
</tbody>
</table>

Signed: | Printed Name: | Today’s Date:
# HEALTH HISTORY FORM

(All answers are optional and confidential. You may leave this form uncompleted if you wish to go over it in person)

<table>
<thead>
<tr>
<th>PATIENT NAME:</th>
<th>ID# (OFFICE USE ONLY):</th>
</tr>
</thead>
</table>

## SECTION I: THE CURRENT PROBLEM

What brings you to physical therapy? What is the problem?

When did this problem first occur (date of onset)? Was there a certain event that caused it?

Where is the problem? What part(s) of your body?

What makes it better? What makes it worse?

At the moment, how bad is this problem? Please rate it from zero to 10, zero being no problem at all.

What would you rate it at its worst?

What would you rate it at its best?

## SECTION II: SOCIAL HISTORY (each of these questions is optional)

With whom do you live, and what is (are) their relationship(s) to you (optional)?

What activities (aside from work) do you enjoy doing or need to do for daily life? How are they limited by this problem?

Do you consume alcohol? If so, how many drinks per week?

Do you use tobacco? If so, how much per week?

## SECTION III: OCCUPATIONAL HISTORY

What do you (or did you) do for a living? How many hours do you (or did you) work in a typical week? If you have retired or stopped working, when?

How would you describe your work duties?
SECTION IV: MEDICATIONS AND ALLERGIES

Please list prescriptions, over-the-counter medications, or nutritional supplements that you take (or attach a list):

PLEASE LIST ANY KNOWN ALLERGIES:

SECTION V: PERSONAL AND FAMILY MEDICAL AND SURGICAL HISTORY

Have you been diagnosed with or treated for any of these? (Check any that apply)

- Breathing or lung (respiratory) problems
- Problems of the heart or blood vessels (cardiovascular)
- Blood pressure or cholesterol problems
- Diabetes
- Infections or infectious disease
- Bone and joint (musculoskeletal) injuries or disorders
- Depression, anxiety, or other psychological disorders
- Alcohol or drug addiction, overuse, or abuse
- Hereditary disorders or diseases
- Glandular (endocrine) disorders (thyroid, prostate, etc.)
- Digestive problems (throat, stomach, bowels)
- Urinary problems
- Kidney (renal) problems
- Liver (hepatic) problems (hepatitis, cirrhosis, etc.)
- Cancer, past or present
- Stroke (cerebrovascular accident)
- Blood disorders (clots, easy bleeding, anemia, etc.)
- Head injury or trauma (including that by violence)
- Other:

Please list any close blood relatives who have been significantly affected by any of these:

Have you recently had any of these? (Check any that apply)

- Trouble breathing
- Chest pain
- Heart palpitations
- Bleeding or bruising
- Leg cramps, redness, or tenderness
- Recent change in weight, appetite
- Feeling fatigued, weak, or sick
- Nausea or vomiting
- Headaches
- Vision changes
- Night sweats
- Worsening pain at night
- Fainting or blackouts
- Dizziness or lightheadedness
- Numbness or tingling
- Trouble swallowing
- Unusual skin changes, sensations
- Urinary or bowel changes/problems
- Unusual lumps
- Sexual problems
- Stiffness in many joints
- Constant, relentless pain
- Sadness or fear
- Confusion or forgetfulness
- Other:

Please list any surgeries you’ve had, with approximate dates:

SECTION VI: SAFETY

Have you fallen recently during normal daily activity?

Do you feel safe at home?

Have you felt threatened, controlled by, or afraid of a partner, family member, or caregiver?

Do you have any other concerns you wish to discuss confidentially?
Your privacy is of utmost importance to us, and Federal law says that you must be informed of your rights and our responsibilities in protecting the confidentiality of every aspect of your treatment at Fairbanks Physical Therapy. The “Privacy Rule” gives you rights over who can access any of your health information, and how it is shared. The Security Rule gives added protection over electronic health information, such as emails we send and receive, and our electronic medical records system.

TO PROTECT YOUR INFORMATION, WE ARE REQUIRED TO

- Put safeguards in place to protect it.
- Reasonably limit use and disclosures to the minimum necessary to accomplish their intended purpose.
- Have contracts in place with our contractors and others ensuring that we use, disclose, and safeguard your health information properly.
- Have procedures in place to limit who can view and access your health information.
- Implement training programs for employees about how to protect your health information.

UNDER THE PRIVACY RULE, WE MUST COMPLY WITH YOUR RIGHT TO

- Ask to see and get a copy of your records
- Have corrections added to your information
- Receive a notice that tells you how your information may be used and shared
- Decide whether to give permission before your information can be used or shared
- Get a report on when and why your information was shared for certain purposes
- Ask us questions about your rights.

WE ARE ALLOWED TO SHARE YOUR INFORMATION IF IT IS NECESSARY

- For your treatment and care coordination
- To pay doctors and hospitals for your health care and to help run their businesses
- With your family, relatives, friends, or others you identify who are involved with your health care or your health care bills, unless you object
- To make sure doctors give good care
- To protect the public's health
- To make required reports to the police, such as reporting gunshot wounds

UNLESS YOU GIVE PERMISSION, WE CANNOT

- Give your information to your employer
- Use or share your information for marketing or advertising purposes
- Share private notes about your health care

IF YOU FEEL WE HAVE VIOLATED YOUR RIGHTS UNDER THIS LAW, YOU CAN

- File a complaint with your provider or health insurer
- File a complaint with the U.S. Government

NOTICE OF FINANCIAL POLICIES

COSTS OF PHYSICAL THERAPY
Depending on your insurance coverage, the actual cost of therapy to you may vary, but therapy is billed at a standard rate. The cost of the initial evaluation portion of your first visit is $186, and you may receive treatment on the first visit as well at additional cost. Upon your request, I will supply you with a more detailed written fee schedule for all therapy services we provide. If you have no insurance, you may receive a “cash payment” discount by paying at the time of service (see below).

THIRD PARTY (INSURANCE) BILLING, AND YOUR RESPONSIBILITIES
As a courtesy, we will bill your insurance and have their payments sent directly to us. You will be responsible for any deductible or co-payment at the time of service. After insurance pays its portion, you’re responsible for the remaining balance, with some exceptions. Many insurance companies, because of our contractual agreements with them, limit the amount that can be billed for therapy (the “allowed amount”), and place a limit on what patients must pay. We encourage you to call your insurance company with some questions about your policy (see the document “Calling Your Insurance Company), take notes, and bring the form to your first therapy visit. If your insurance changes, please let us know as soon as possible, to avoid insurance denial of a claim.

NON-INSURANCE-FEE-FOR-SERVICE (THE “CASH-PAY DISCOUNT”)
If you have no insurance, or prefer not to have your insurance billed, you may opt for a fee-for-service or “cash-pay” discount. If all charges are paid at the time of service, we’ll discount our standard fees by 30%.

CANCELLATIONS AND MISSED APPOINTMENTS
If you need to cancel an appointment, please let us know at least 24 hours in advance. If you miss a scheduled appointment or cancel with less than 24-hours notice, you will be billed $50 (this late cancellation fee is not reimbursed by insurance companies). We do not charge for missed appointments or late cancellations due to illness.

PAYMENT AND BILLING
All co-pays and deductibles must be paid at the time of service. If you have concerns about the cost of your care, please ask us about our reasonable Payment Plans.

We accept payments of cash, credit card and paypal.

PLEASE FEEL FREE AT ANY TIME TO ASK FOR CLARIFICATION OF THESE POLICIES, OR TO DISCUSS ANY FINANCIAL CONCERNS YOU MAY HAVE. Thank you for your time.
INSTRUCTIONS: It is important and necessary to be informed about your health benefits under your insurance policy, so that you may make informed decisions about purchasing health care services. If you will be using any private, non-government-sponsored health insurance to pay for therapy (including secondary insurers), we ask that you take a few minutes and call the toll-free number on your insurance card.

WHAT TO SAY: “I’d like to ask some questions about my outpatient physical therapy benefits.” Then ask them the following questions, write down the answers, and bring the completed form with you to your first physical therapy visit.

| 1. Do I need to have a physician’s prescription for therapy? |
| 2. What is my co-pay for a therapy visit? |
| 3. How many visits are allowed? |
| 4. How many visits have I used to date? |
| 5. What is my annual deductible for outpatient physical therapy? |
| 6. How much of my deductible have I met? |
| 7. When does my “benefit year” start (beginning of the calendar year or not)? |
| 8. Do I need pre-authorization? If so, what number do I call? (If this is required, please call the number before your first visit.) |
| 9. What rules apply to my authorization? For example, do I have to get re-authorized after a certain number of visits, or every year on a certain date? |
| 10. Do I have “out-of-network” benefits for outpatient physical therapy services? If so, please summarize them. |