ELITE PHYSICAL THERAPY
& WELLNESS

TODAY'S DATE: _____

PATIENT REGISTRATION

Patient Name: (Last) _____ (First) _____ (M.I.) _____ SS #: _____ Birth Date: _____ Marital Status: _____ Gender: ____Male ____Female
Email: _____
Address: _____ City: _____ State: _____ Zipcode: _____ Home #: _____ Work #: _____ Cellphone #: _____

if patient under 18
Parent/Spouse Name: (Last) _____ (First)_____ (M.I.) _____
Parent/Spouse Employer: _____ Occupation: _____
Address: _____ City: _____ State:_____ Zipcode: _____
Home #: _____ Work #: _____ Cellphone #: _____

Date Of Illness/Injury/Accident: _____ Referring Doctor: _____ Phone #: _____
How did you hear about Elite Physical Therapy and Wellness? _____

Primary Insurance
Policy Name: _____ Address: _____ Phone #: _____ ID/Policy #: _____ Group #/Name: _____ Policyholder/Subscriber Name: _____ Policyholder/Subscriber SS #: _____ Policyholder/Subscriber DOB: _____

Secondary Insurance
Policy Name: _____ Address: _____ Phone #: _____ ID/Policy #: _____ Group #/Name: _____ Policyholder/Subscriber Name: _____ Policyholder/Subscriber SS #: _____ Policyholder/Subscriber DOB: _____

Workmen's Compensation Attorney Information Date of Accident/Injury: _____
Attorney Name: _____ Address: _____ City, State, Zip: _____ Phone #: _____ Fax #: _____

Insurance Carrier: _____
Address: _____ City, State, Zip: _____ Phone #: _____ Fax #: _____ Claim #: _____ Claim Adjuster: _____

Automobile Accident Information Date Of Accident: _____ Auto Insurance Name: _____ Driver: Yes _____ No _____ Address: _____ Name of Insured/Policyholder: _____ Policy #: _____ Phone #: _____ Claim #: _____ Insurance Agent Name: _____

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ASSIGNMENT OF MEDICAL BENEFITS, PRIVACY RIGHTS, AND CONSENT FOR TREATMENT

THE UNDERSIGNED, hereby certify that all information provided to Provider by the undersigned or Patient, including any information in connection with applying for a payment under Title XVIII of the Social Security Act, is true and accurate in all respects.

THE UNDERSIGNED, hereby authorize Provider to disclose any information, furnished to Provider or obtained by provider in connection with Patient's treatment (including information concerning a related Medicare claim), to any physician, governmental agency (including the Social Security Administration or any of its intermediaries or carriers), insurance company or health care facility requesting such information.

THE UNDERSIGNED, hereby assign to Provider all Medicare benefits and Medicaid benefits to which Patient may be entitled for any Therapy Services rendered by Provider. The undersigned hereby authorize and direct Provider to apply and file for all such benefits on behalf of Patient. In the event Patient is covered by both Medicare and Medicaid, Patient's Medicare deductible and any applicable Medicare co-payment will be covered by Medicaid. The undersigned acknowledge that Provider has disclosed to the undersigned that Provider is a supplemental Medicaid provider and that Provider is paid directly by Medicaid. In addition, the undersigned approves contact with the appropriate family members for medical claims management process.

THE UNDERSIGNED, hereby assign to Provider all private medical insurance benefits or other benefits to which Patient may be entitled for any Therapy Services rendered by Provider. The undersigned hereby authorize and direct provider to apply and file for all such benefits on behalf of Patient.

THE UNDERSIGNED, authorizes Elite Physical Therapy and Wellness LLC to deposit checks received on Patient's account when made out to the patient or signed over by the patient when Insurance Company pays against services provided.

THE UNDERSIGNED, agrees that, he/she, shall be financially responsible for any portion of Provider's invoice that is not paid, except in the event of Medicare denial or Medicaid eligible recipients. The undersigned warrant and represent to Provider that Patient is not a member of, or covered by, a health maintenance organization or similar arrangement. The undersigned shall be liable to Provider for all services rendered by Provider in the event Patient is covered by a health maintenance organization or similar arrangement.

THE UNDERSIGNED and patient agree to execute any documents and perform any act that Provider may reasonably request. The undersigned warrant and represent that attached hereto are originals or certified copies of any applicable powers of attorney, health care surrogate forms or court orders appointing the undersigned as the legal guardian of the Patient.

THE UNDERSIGNED, agree that the provisions hereof shall continue in full force and effect until Provider has received written notice of termination signed by the undersigned; provided, however, that the provision of paragraphs 2, 4, 5, and 6 shall survive any such termination.

THE UNDERSIGNED, acknowledge that Provider has disclosed to the undersigned that no physician owns any interest in Provider.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS I hereby authorize Elite Physical Therapy and Wellness LLC, to obtain my Protected Health Information including, but not limited to: history and physical exam, lab reports, progress notes, X-Ray reports, substance abuse (including alcohol/drug abuse), mental health (including psychotherapy notes), and HIV related information (including AIDS related testing). I understand that this authorization will expire 365 days from the date I have signed this form and that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified, except to the extent action has already been taken in reliance upon it. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal Privacy regulations.

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PRIVACY NOTICE By my signature below, I acknowledge that I may request a copy of this practice's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law and understand my rights as a patient regarding my personal health information.

Patient Signature/Legal Representative/Insured Party_____

Date:_____

Medical/Social History

Patient Name: _____ Date: _____ Date of Birth: _____ Age:_____
Gender: ____Male ____Female
Are you: ____ Right-handed ____ Left-handed

MEDICAL HISTORY(check all that apply) ___ Diabetes: Insulin/meds/diet ___ Liver disease/hepatitis
___ Stomach ulcers ___ Stroke ___ Anemia ___ Mental health disorder ___ Seizures ___ Bowel/intestinal problems
___ Bleeding disorders ___ Glaucoma ___ Kidney disease/stones ___ Blood clots ___ Ear/nose/throat/mouth issues ___ Hiatal hernia___ Blood transfusions ___ Asthma ___ Skin disease ___ Treatment of drug and/or alcohol problems
___ Thyroid: hypo or hyper ___ Prostate disease ___ History of cancer _____ ___ Lung problems
___ Gynecologic disease ___ Peripheral neuropathy ___ Heart problems ___ Are you pregnant? ___
Other _____
___ High blood pressure ___ Arthritis ___ High cholesterol ___ HIV/AIDS
___ Pacemaker
___ No known medical problems

List Any Drug Allergies: _____
Latex Sensitive: ___ No ___ Yes _____

List All Previous Surgeries: _____ Month/Year_____
_____ _____
_____ _____
List Current Medications: Prescription _____ _____
_____ _____
_____ _____

SOCIAL HISTORY (check all that apply)
Marital status: ___ Married ___ Single ___ Divorced ___ Widowed
With whom do you live? _____
Does your home have stairs? ___ No ___ Yes If yes how many?____ railings?____
Current work status? ___ Employed ___ Homemaker ___ Retired ___ Unemployed ___ Disabled
Occupation? _____
Job duties impacted by injury/pathology? _____
Current smoker? ___ No ___ Yes
How many packs per day? ____ How many years? _____
Alcohol use? ___ Never/rarely ___ Once/day ___ Once/week ___ Once/year
Hobbies or interests? _____
Regular exercise? ___ Once/month ___ Once/week ___ 2-5 times/week ___ Once/day
Type of exercise? _____

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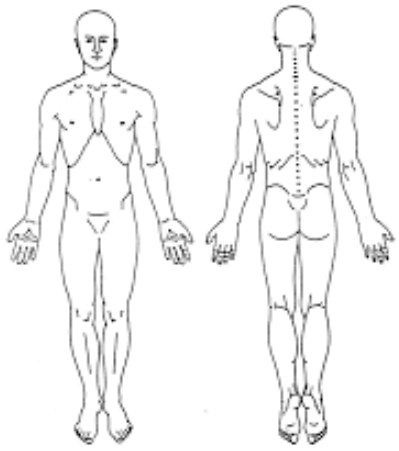
At the present time, would you say your health is excellent, very good, good, fair, or poor?
_____

History of current illness/injury

Patient Name: _____

Are you currently seeing any other health care provider for this condition? ___ No ___ Yes
Who? _____ Have you been discharged from the hospital, a skilled nursing facility, or home health agency in the past 30 days related to this condition? ___ No ___ Yes ___
When did your symptoms start?
_____
Can you identify a cause for your symptoms? ___ No ___ Yes,
Describe:



_____
_____ Have you ever had similar symptoms in the past? ___ No ___ Yes, When? _____
Did you have any prior limitations in function or daily activities? ____ No ___ Yes
Were you able to perform all activities of daily living independently prior to onset? ___ No ___ Yes
Since the onset of your problem, have you had any of the following tests? ___ No ___ Yes
If yes, check all that apply: ____X-Ray ___Bone Scan ___Myelogram ___CT Scan ___MRI ___EMG ___Other

PAIN RATING: Indicate your level of pain by circling the appropriate number on the scales below.
0= no pain and 10=emergency room pain

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 **(current)**

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 **(at its worst)**

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0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 **(at its best)**

Please mark/shade areas of pain on body diagram
X=numbness/tingling/burning
0=dull
/=sharp

Do you have numbness or tingling? ___ No ___ Yes, Where? _____ Have you had any changes in Bowel or Bladder? ___ No ___ Yes,Explain:_____
Have you had any unexplained weight loss? ___ No ___ Yes, How much? _____ lbs.
Have you had any unexplained weight gain? ____ No ___ Yes, How much? _____ lbs.
Have you had a fall which resulted in an injury in the last year? ___ No ___ Yes
Have you fallen more than twice in the last year? ___ No ___ Yes
During the past month, have you often been bothered by feeling down, depressed, or hopeless? ___ No ___ Yes
During the past month, have you often been bothered by little interest or pleasure in doing things? ___ No ___ Yes

What are your goals for physical therapy? _____
Is there anything else you wish the therapist to know about your condition?
_____

I have completed this form to the best of my ability and acknowledge that the information is correct.

_____ _____
Patient Signature Date