Patient Registration

Atlas Physical Therapy

Date: _____

Name (First, Middle, Last): _____

Nickname: _____

Primary Phone: _____ Cell Home Work (circle one)

Social Security Number: _____

Primary Address: _____

Email: _____

Insurance: _____ Secondary: _____

Policy Holder (if other than self): _____

DOB of Policy Holder: _____ Relationship: _____

Referring Doctor: _____

Primary Care Doctor: _____

How did you hear about us?: _____

P: 410.762.2124
F: 410.705.5057

atlas@iwantpt.com
www.iwantpt.com

1406 Crain Hwy S
Suite 110
Glen Burnie, MD 21061

Patient Pre-Exam Form

Atlas Physical Therapy

Patient Name: _____Date: _____

Where is your pain/problem? _____

What caused your problem? _____

Date when problem started or worsened _____(mm)/_____(dd)/_____(yy)

Pain Description (circle all that apply):

Sharp	Achy	Numb/Tingling	Constant	Intermittent	n/a

WORST your pain has been in the past week? (0=no pain, 10=worst pain)

0	1	2	3	4	5	6	7	8	9	10

Your CURRENT pain level ? (0=no pain, 10=worst pain)

0	1	2	3	4	5	6	7	8	9	10

BEST your pain has been in the past week? (0=no pain, 10=worst pain)

0	1	2	3	4	5	6	7	8	9	10

Medical History:

- ○ None
- ○ High Blood Pressure
- ○ Pacemaker
- ○ Chronic Pain
- ○ Stroke
- ○ Current Smoker
- ○ Diabetes
- ○ Cancer
- ○ Mental Health
- ○ Fractures
- ○ Fibromyalgia
- ○ Osteoporosis
- ○ Osteopenia
- ○ Other:

_____

_____

Past Surgeries & Dates: _____

_____

Current Medications: (list each or provide staff with written list): _____

_____

Have you had any falls in the past year? (circle one) YES NO

Height: _____ Weight: _____

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Policies - Please initial each.

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_____Attendance Policy:

I am responsible for attending physical therapy sessions as scheduled. I understand if I am late or fail to give appropriate cancellation notice, I will hinder my potential outcome. I understand that my physical therapist has designated appointment times to assist me in my recovery. I will provide **at least 24 hours' notice** to cancel a scheduled appointment. Failure to comply with this policy may result in a $65.00 charge. I understand that this charge will be billed DIRECTLY to me, the patient, and is NOT covered by insurance.

_____HIPPA:

I am aware of Atlas Physical Therapy's HIPPA policy and how my personal and medical information will be used. I am aware that I can request the document in its entirety from any staff member, at any time.

_____Consent to treat:

I hereby agree and give my consent for Atlas Physical Therapy to provide physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition. This consent is intended as a waiver of liability for such treatment, excluding acts of negligence.

_____Financial Responsibility:

I agree that I am ultimately responsible for any charges incurred at Atlas Physical Therapy for services rendered.
I hereby agree to the policies that I have acknowledged with my initials above.

_____ _____
Patient Signature Date

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Atlas
Physical Therapy

NO SHOWS & LAST MINUTE CANCELLATION POLICY

Please understand that missed appointments impact the clinic and the availability of the therapist's time for other patients. It is very important to show up to your appointment *on time*.

You will be charged $65 for a missed or if you are too late to be seen appointment as well as a cancellation without 24 hours notification.

This charge must be paid by you - Your insurance will not cover charges for missed appointments.

_____ _____

Patient Signature Date

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