REGISTRATION FORM

PATIENT INFORMATION

NAME: ____
FIRST MI LAST

ADDRESS: ____
NUMBER/STREET APT. CITY STATE ZIP CODE

DATE OF BIRTH: ____________ AGE: ______ GENDER: ☐ MALE ☐ FEMALE ☐ OTHER ______

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ OTHER ______

CONTACT: HOME ____________ CELL ____________ EMAIL ____________

APPOINTMENT REMINDERS: TEXT VOICE CALL NONE

EMERGENCY CONTACT #: ____________ NAME/RELATIONSHIP: ____________

DOCTOR INFORMATION

REFERRING PHYSICIAN: ____

ADDRESS: ____
NUMBER/STREET CITY STATE ZIP CODE

PHONE NUMBER: ____________ FAX NUMBER: ____________

PRIMARY PHYSICIAN: ____________ PHONE NUMBER: ____________

Have you received Physical Therapy or Occupational Therapy treatment within the last 12 months? ☐ YES ☐ NO

Have you attended any Chiropractic, Speech Therapy or Home Care? ☐ YES ☐ NO

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: ____________________

MEMBER ID #: ____________________ GROUP ID #: ____________________

Is this the Patient's insurance? ☐ YES ☐ NO If NO, who is the policy holder: ____________________

POLICY HOLDER DOB: ____________________ RELATIONSHIP TO PATIENT: ____________________

SECONDARY INSURANCE COMPANY: ____________________

MEMBER ID #: ____________________ GROUP ID #: ____________________

Is this the Patient's insurance? ☐ YES ☐ NO If NO, who is the policy holder: ____________________

POLICY HOLDER DOB: ____________________ RELATIONSHIP TO PATIENT: ____________________

ACCIDENT INFORMATION

Auto (NF) or Workers Compensation (WC)

Is this work related? ☐ YES ☐ NO Auto accident? ☐ YES ☐ NO DATE OF ACCIDENT/INJURY: ____________________

WHICH STATE DID THE ACCIDENT OCCUR IN: ____________________ Surgery? ☐ YES ☐ NO DATE OF SURGERY: ____________________

ATTORNEY INFORMATION: ____________________
NAME FIRM

ATTORNEY ADDRESS: ____________________
NUMBER/STREET CITY STATE ZIP CODE

NF/WC INSURANCE CARRIER: ____________________

CLAIM #: ____________________ POLICY #: ____________________

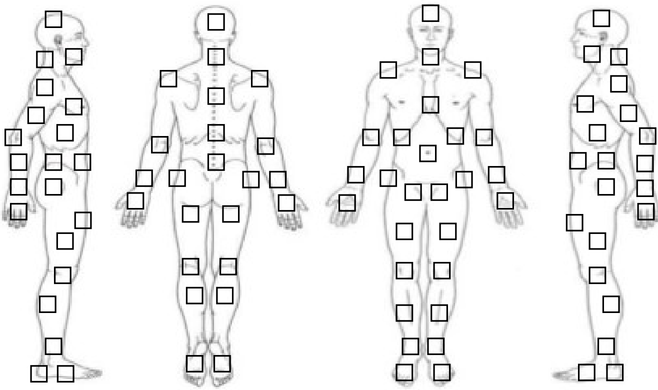
ADJUSTER NAME: ____________________ PHONE NUMBER: ____________________

ADJUSTER EMAIL: ____________________ FAX NUMBER: ____________________

Is your claim open? ☐ YES ☐ NO Is your adjuster aware you are starting therapy? ☐ YES ☐ NO

MEDICAL HISTORY

Please indicate where you have pain or other symptoms



None → *Emergency Room pain*

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

MEDICATIONS:

Please list all over the counter and prescription medications you are currently taking. Include dosage & frequency.

____

____

____

SURGICAL HISTORY:

List any surgical procedures you have had and the dates they were performed.

____

____

____

DIAGNOSTIC TESTING:

Please check any diagnostic testing and/or treatments you have completed for this condition.

☐ MRI
☐ CT Scan
☐ Nerve Block
☐ Ultrasound
☐ X Ray
☐ Bone Scan
☐ Blood Tests
☐ Doppler Studies
☐ EMG
☐ Cardiac Stress Test
☐ Injections
☐ Urinalysis
☐ Other: ______________________________

☐ Congenital Heart Defect
☐ Cancer
☐ Heart Problems/Heart Disease
☐ Joint Replacement/Repair
☐ Joint, Tendon or Muscular Pain
☐ Gastrointestinal Issues
☐ Osteoporosis
☐ Skin Problems
☐ Pacemaker
☐ Psychological
☐ High or Low Blood Pressure
☐ High or Low Blood Sugar
☐ Chest Pain/Angina/Palpitations
☐ High Cholesterol
☐ Abdominal Pain/Bloating/Gas
☐ Emphysema
☐ Shortness of Breath
☐ Poor Balance Recent Falls
☐ Coughing/Wheezing or Exertion
☐ Dizziness/Vertigo/Fainting/Blackouts
☐ Gout
☐ Severe Headaches
☐ Rheumatoid Arthritis
☐ Prostate Problems
☐ Anemia
☐ Epilepsy/Seizure Disorders
☐ Ulcers
☐ Circulation Problems/ Blood Clots
☐ Depression
☐ Liver Disease
☐ Kidney Disease
☐ Sexually Transmitted Disease/HIV/AIDS
☐ Tuberculosis
☐ Lung Disease
☐ Thyroid Problems
☐ Allergies
☐ Asthma/Bronchitis/Pneumonia/Chronic Cough
☐ Diabetes
☐ Stroke
☐ Chemical Dependency (Alcoholism)
☐ Latex Allergy
☐ Lyme Disease
☐ Hepatitis A, B, C
☐ Painful Bowels/Loose Stool/Constipation
☐ Multiple Sclerosis
☐ Depression/Anxiety/Panic Attacks

☐ Other: ______________________________

PATIENT FINANCIAL RESPONSIBILITY

“**Denials/Appeals**”: It is a patient’s responsibility to initiate an appeal with the insurance provider when services are denied.

Katura Health will provide the necessary clinical information upon request.

If your insurance company determines that services are no longer medically necessary, you will be billed for services that have been rendered.

I understand it is my responsibility to confirm my coverage with my insurance carrier and that Katura Health may verify such coverage as a courtesy to me. Katura Health will not be held responsible or liable for inaccurate information or denials provided by your insurance carrier after services have been rendered.

My signature below acknowledges that I have read and fully understand that:

1. Katura Health has discussed clinically appropriate care and specific number of office visits allowed per my insurance company.
2. I have been informed of my financial responsibility if my insurance company denies all or part of these services as not medically necessary.
3. I fully accept the financial responsibility to pay for denied services at the time my insurance carrier deems my treatment not medically necessary.
4. You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, co-insurance amounts or any other patient responsibility indicated by your insurance carrier.

PATIENT NAME: ______________________ DATE: ______________

PATIENT SIGNATURE: ______________________

CONSENTS AND DISCLOSURES

(I) CONSENT TO RELEASE INFORMATION TO FAMILY OR FRIENDS

Ordinarily, discussion of medical records or billing information would not be disclosed to anyone but yourself over the phone. However, with your consent, our staff will speak with your significant other, close family member or other designated individual. Please understand that you are waiving your right to confidentiality if this consent is given.

__________ INITIAL HERE TO GIVE CONSENT

I am hereby giving my consent to Katura Health office staff to discuss my medical condition or billing concerns with the person/ persons I have designated below.

NAME: ______________________________ RELATIONSHIP: ______________________

NAME: ______________________________ RELATIONSHIP: ______________________

NAME: ______________________________ RELATIONSHIP: ______________________

(II) CONSENT TO RELEASE INFORMATION TO A TELEPHONE ANSWERING MACHINE

In an effort to protect your confidentiality, medical history and appointment reminder specifics (including date & time) will not be left on your answering machine, email and/or received in a text message; however, if you prefer us to do this, we can with your consent. Please understand that you are waiving your right of confidentiality if you give your permission.

__________ INITIAL HERE TO GIVE CONSENT

I am hereby giving my consent for the Katura Health office staff to leave medical history or appointment reminders (including date & time) on my telephone answering machine, email and/or text message.

__________ INITIAL HERE TO DECLINE CONSENT

(III) PATIENT AUTHORIZATION TO TREAT AND SUBMIT MEDICAL CLAIMS

I authorize payment to Katura Health LLC for all physical therapy services rendered. I also understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.

I consent to be assessed by and to receive treatment from Katura Health LLC consistent with a plan of care. I confirm that I have been informed and have participated in planning the care and procedure(s) to be carried out by Katura Health LLC and sign this consent willingly and voluntarily.

I consent to the release of information and/ or disclosure to Katura Health, LLC of all or any part of my medical record to other health care providers involved in my care or third-party payers as is necessary for processing claims.

I am aware my child is receiving Physical Therapy at Katura Health I am unable to attend his/her office visits. Please accept this form as my consent to treat my child.

____

PARENT/ GUARDIAN INITIALS IF APPLICABLE:

I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENTS AND DISCLOSURES.

PATIENT SIGNATURE: ______________________________ DATE: ______________

PARENTAL SIGNATURE FOR MINOR: ______________________________ DATE: ______________

ATTENTION

KATURA HEALTH NO SHOW/CANCELLANTION POLICY

As a courtesy to other patients, as well as the Katura Health staff, we would appreciate a call of notification to cancel appointments at least 24 hours prior to your scheduled appointment. Please make sure to reschedule your appointment after canceling. If a no call is received/documented your visit will be counted as a "**NO SHOW**."

In reference to missing or not showing to your scheduled appointment without prior notification, a fee of $30 will be collected upon your next visit. Hopefully, this policy will ensure better scheduling availability as to not block appointments for other patients. Should there be any misunderstandings or miscommunications regarding your scheduled appointment, please speak to our office manager.

PATIENT SIGNATURE: ______________________________

MEDIA

SIGN HERE TO GIVE CONSENT, for Katura Health office staff to use photos of treatment and interaction with therapist after verbal consent for social media and marketing purposes. We are a digital clinic capturing moments on the fly

PATIENT SIGNATURE: ______________________________

VERIFICATION OF BENEFITS

Katura Health verifies patient benefits with your insurance carrier as a courtesy to the patient. Benefits quoted are not a guarantee of payment. Patient is ultimately responsible for any denied services rendered at Katura Health.

PATIENT BILL OF RIGHTS

Katura Health strives to ensure that each patient is provided the highest quality of care in accordance with high professional standards that are continually maintained and reviewed. By requiring informed consent for treatment, we assure that each patient and/or his/her representative is involved in aspects of a treatment plan. Patients and their representatives are afforded consideration of their privacy concerning their own medical care program. Case discussion, consultation, examination and treatment are considered confidential and should be conducted discretely. The patient has the right to full information in layman's terms concerning diagnosis, treatment and prognosis, including information about alternative treatments and possible complications. We will endeavor to involve patients in their treatment program by incorporating their feeling, interest, attitudes and goals in the treatment planning and implementation process. A patient has the right to physical therapy services without discrimination based upon race, color, religion, sex, sexual preference or national origin.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE PATIENT BILL OF RIGHTS.

PATIENT SIGNATURE: ______________________________ DATE: ______________

PARENTAL SIGNATURE FOR MINOR: ______________________________ DATE: ______________