WINGHAVEN MANUAL PHYSICAL THERAPY
PATIENT REGISTRATION FORM

This is a fillable form.

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ☐ M ☐ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ☐ Dr. _____ ☐ Insurance Plan ☐ Family ☐ Friend ☐ Facebook ☐ Close to home/work ☐ Internet search ☐ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance ☐ Medicare ☐ UHC ☐ Anthem BCBS ☐ Cigna ☐ Aetna ☐ Coventry ☐ Tricare ☐ Humana ☐ Group Health ☐ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize Winghaven Manual Physical Therapy or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

Please Email this form back to office@winghavenmanualpt.com or Fax to 636-625-0411

WINGHAVEN MANUAL PHYSICAL THERAPY

21 Meadows Circle Dr., Suite 320
Lake Saint Louis, MO 63367
Phone: 636-625-0408 Fax: 636-625-0411

Manual Therapy Consent Form

At Winghaven Manual Physical Therapy, our therapists have specialized training in manual therapy, including joint mobilization and manipulation, soft tissue work, and myofascial techniques. We will perform a thorough evaluation and assessment, explain the plan of care, and discuss your goals for therapy before implementing any treatment. To ensure you have an understanding you may receive manual therapy during your visits, please read and sign below.

I, _____, understand I may receive manual therapy and agree with the following statements:

1) I must inform the treating therapist if any signs or symptoms occur which make me uncomfortable or uneasy. These include but are not limited to: nausea, dizziness, numbness, vertigo, visual disturbance, pain.
2) I am responsible for communicating with the therapist during any manual treatment or procedure (such as dry needling) if I experience any negative effects; and, my therapist will stop upon request.
3) I agree to remove articles of clothing that may prevent effective treatment of an area, and I expect the therapist will provide covering when able and respect my privacy.
4) I understand after receiving manual treatment I may experience temporary symptoms such as local soreness, stiffness, headache, or referred/radiating symptoms. I will report these symptoms to the therapist and understand they are not uncommon, particularly after high velocity/low amplitude joint manipulation.
5) I realize I have the right to refuse any treatment at any time and will communicate with my therapist any concerns.

I have read and agree with the above statements and declare I am willing to receive manual therapy treatment. I will seek medical treatment if injury occurs from techniques.

_____	_____	_____
Patient name (Print)	Patient signature	Date

_____	_____
Physical Therapist signature	Date

Winghaven Manual Physical Therapy

Patient Health Questionnaire

Name: _____ **Age**: _____ **Height**: _____ **Weight**: _____ **Gender**: _____

Have you or an immediate family member ever had: (if yes, explain)

	Y N	
Cancer	Y / N	_____
High Blood Pressure	Y / N	_____
Diabetes	Y / N	_____
Heart Disease	Y / N	_____
Angina/Chest Pain	Y / N	_____
Stroke	Y / N	_____
Arthritis	Y / N	_____

Do you have a history of:

	Y N
Shortness of Breath	Y / N
Polio	Y / N
Allergies	Y / N
Emphysema	Y / N
Asthma	Y / N
Anemia	Y / N
Bronchitis	Y / N
Rheumatic Fever	Y / N
Kidney Disease/Stones	Y / N
Ulcers	Y / N

Do you experience any of these symptoms:

	Y N
Nausea/Vomiting	Y / N
Dizziness	Y / N
Fever/Chills/Sweats	Y / N
Night pain	Y / N
Unexplained Weight Change	Y / N
Headaches	Y / N
Numbness/Tingling	Y / N
Muscular Weakness	Y / N
Loss of Balance/Falls	Y / N
Bowel or Bladder Changes	Y / N

Have you had surgery for this problem? Y ☐ N ☐

If yes, date and type of surgery: _____

Have you received previous treatment for this problem? Y ☐ N ☐

If yes, please explain: _____

Have you had any recent upper respiratory infections (flu) or urinary tract infections? Y ☐ N ☐

Do you smoke? Y ☐ N ☐ **Do you drink alcohol?** Y ☐ N ☐ **Do you use caffeine?** Y / N

List regular exercise/activity (prior to this problem): _____

_____

Winghaven Manual Physical Therapy
At the Meadows

Notice of Privacy Practices (HIPAA)

This notice explains how medical information about you may be used and disclosed and how you may obtain access to this information. Please read carefully.

Winghaven Manual Physical Therapy is dedicated to protecting the privacy of your medical information. We are required by law to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. Winghaven Manual Physical Therapy is required by law to abide by the terms of this Notice.

How your medical information will be used and disclosed:

We will use your medical information to provide optimal patient care. For example, your information may be used to communicate with other healthcare professionals treating you, to process your payment for the services rendered, and to review the quality of the care you receive.

We may also use and/or disclose your information in accordance with federal and state laws for the following purposes:

- Appointment Reminders. (We may contact you to provide appointment reminders.)
- Treatment Information. (We may contact you with information about treatment alternatives or health-related benefits/services that may be of interest to you.)
- Disclosure to Department of Health and Human Services. (We may disclose medical information when required by the United States Department of Health and Human Services as part of an investigation or determination of our compliance with relevant laws.)
- Family and Friends. (If you agree, we may disclose pertinent medical information to family members, relatives or close friends when the information is directly relevant to that person's involvement with your care.)
- Notification. (If you agree, we may use or disclose your medical information to notify a family member, a personal representative or another person responsible for your care of your location, general condition or death.)
- Disaster Relief. (We may disclose your medical information to a public or private entity for the purpose of allowing them to assist in disaster relief efforts.)

- Health Oversight Activities. (We may use or disclose your medical information for public health activities, including the reporting of disease, injury, vital events and the conduct of public health surveillance, investigation and/or intervention. We may disclose your medical information to a "health oversight agency" for oversight activities authorized by law, including audits, investigations, legal or administrative proceeding, inspections, and licensure or disciplinary actions.)

- Abuse or Neglect. (We may disclose your medical information when it concerns abuse, neglect or violence to you in accordance with federal and state law.)

- Legal Proceedings. (We may disclose your medical information in the course of certain judicial or administrative proceedings.)

- Law Enforcement. (We may disclose your medical information for law enforcement purposes or other specialized governmental functions.)

- Coroners, Medical Examiners and Funeral Directors. (We may disclose your medical information to a coroner, medical examiner or a funeral director.)

- Research. (We may use or disclose your medical information for research purposes if an Institutional Review Board or a privacy board has altered or waived individual authorization, the review is preparatory to research or the research is only on decedent's information.)

- Public Safety. (We may use or disclose your medical information to prevent or lessen a serious threat to the health or safety of another person or to the public.)

- Workers' Compensation. (We may disclose your medical information as authorized by laws relating to workers' compensation or similar programs.)

- Business Associates. (We may disclose your health information to a business associate with whom we contract to provide services on our behalf. To protect your health information, we require our business associates to uphold HIPAA.)

Authorizations:

We will not use or disclose your medical information for any other purpose without your written authorization. Once given, you have the right to revoke your authorization in writing at any time. You may request a Revocation of Authorization form at Winghaven Manual Physical Therapy if needed.

Your rights regarding your medical information:

You have the following rights with respect to your medical information:

• You may ask us to restrict certain uses and disclosures of your medical information. Although we are not required to agree to your request, we will honor it if we do agree.

• You have the right to receive all communications from us in a confidential manner.

• You may inspect and copy your medical information. This right is subject to certain specific exceptions. You may be charged a reasonable fee for any copies of your records.

• You may ask us to amend your medical information. We may, however, deny your request for certain specific reasons. If we deny your request, we will provide you with a written explanation for the denial and information regarding further rights you may have at that point.

• You have the right to receive an accounting of the disclosures of your medical information made by Winghaven Manual Physical Therapy for the last six years (or following August 2017), except for disclosures for treatment, payment or healthcare operations, disclosures which you authorized and certain other specific disclosure types.

• You may request a paper copy of this Notice of Privacy Practices for Protected Health Information.

• You have the right to complain to us and/or to the United States Department of Health and Human Services if you believe that we have violated your privacy rights. If you file a complaint, you will not be retaliated against in any way. To make a complaint, please contact Dan Washeck or Cindy Washeck at Winghaven Manual Physical Therapy.

If you would like further information regarding your rights or regarding the uses and disclosures of your medical information, contact: Winghaven Manual Physical Therapy.

THIS NOTICE IS EFFECTIVE AS OF: August 2017.

REVISION OF NOTICE OF PRIVACY PRACTICES

We reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post revisions at Winghaven Manual Physical Therapy's website and will make paper copies of the revised Notice of Privacy Practices available upon request.

*The Proposed rule issued 3/02 eliminated the consent requirement for uses and disclosures for treatment, payment and health care operations and replaced it with a requirement that health care providers with a direct treatment relationship with the patient make a good faith effort to obtain an acknowledgment that the patient received the provider's Notice of Privacy Practices.

Acknowledgement of Notice of Privacy Practices

Winghaven Manual Physical Therapy
At the Meadows

I have been provided a copy of the Notice of Privacy Practices for Winghaven Manual Physical Therapy. I have reviewed the information and understand my rights as a patient and the legal obligations of Winghaven Manual Physical Therapy to preserve the privacy of my personal health information.

Name of patient/legal guardian

Signature of patient/legal guardian Date

If you have any questions, concerns, or complaints about this Notice or your protected health information, please contact Dan Washeck or Cindy Washeck at 636-625-0408.