ONONDAGA PHYSICAL THERAPY
helping you live, work and play better

Registration Form
(Please Print Clearly)

PATIENT INFORMATION

TODAY'S DATE: / / PRIMARY CARE PHYSICIAN:

Patient's Last Name	First	Middle	What would you prefer to be called?

Street Address	City	State	Zip Code

Home Phone	Work Phone (extension)	Cell Phone	Sex	Age	Date of Birth
			□ Male □ Female		/ /

Email Address:	How would you like us to keep in touch with you?
	□ Email □ Postal Mail

Marital Status	Employment Status	Accident?	Date Of Next Physician Appt
□ Single □ Married □ Widowed □ Divorced	□ Full □ Part □ Retired □ Not Employed □ Other	□ None □ Auto □ Work □ Other	/ /

INSURANCE INFORMATION (Please Show Your Insurance Cards)

Primary Insurance	Policy Holder Name	Policy Holder DOB	Insurance Card ID #	Group #

Patient Relationship To Policy Holder: □ Self □ Spouse □ Child □ Other_____

Secondary Insurance	Policy Holder Name	Policy Holder DOB	Insurance Card ID #	Group #

Patient Relationship To Policy Holder: □ Self □ Spouse □ Child □ Other_____

IN CASE OF EMERGENCY

Contact Name	Relationship To Patient	Home Phone	Cell Phone

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Onondaga Physical Therapy, LLC. I understand that I am financially responsible for any balance that is unpaid by my insurance company. I understand Onondaga Physical Therapy will impose a late fee of $25 for any balance that is older than 90 days, unless I have prior payment arrangements. I further authorize Onondaga Physical Therapy, LLC and my insurance company to release any information that is required to process my claims.

I hereby consent to treatment procedures and patient care which in the judgment of my therapist and/or physician may be considered necessary or advisable while I am a patient of Onondaga Physical Therapy, LLC.

I hereby authorize the use or disclosure of my individually identifiable health information as described in the NOTICE OF PRIVACY PRACTICES I received.

X _____

PATIENT/GUARDIAN SIGNATURE DATE

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Medical History Form

(Please Print Clearly)

Name:	Date:

Have you EVER been diagnosed as having any of the following conditions?

Yes No Heart Problems	Yes No Epilepsy / Seizures	Yes No Implanted Devices
Yes No High Blood Pressure	Yes No Hearing Loss / Disorder	Yes No Cancer
Yes No Pacemaker	Yes No Eye Disease	Yes No Osteoporosis
Yes No Rheumatoid Arthritis	Yes No Muscular Disease / Disorder	Yes No Depression
Yes No Other Arthritic Condition	Yes No Multiple Sclerosis	Yes No Past Pregnancy
Yes No Stroke	Yes No Tuberculosis	Yes No Currently pregnant
Yes No Lung Disease	Yes No Circulation Problems	Yes No Chemical Dependency
Yes No Asthma	Yes No Hepatitis	Yes No Other:
Yes No Diabetes	Yes No Kidney Disease	

Please list any surgeries or other medical conditions for which you have been treated

Date	Surgery/Injury/Condition	Reason:

List all medications you are currently taking (pills, injections, inhalers, skin patches):

Any additional comments or information you would like us to know:

X _____

PATIENT/GUARDIAN SIGNATURE DATE

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HIPAA Privacy Information

TODAY'S DATE: / /

PATIENT INFORMATION

Patient's Last Name First Name Date of Birth

CONTACT METHODS

Please check the appropriate boxes indicating acceptable ways for us to contact you regarding either your appointment(s) or other medical information. By checking these boxes, you give us permission to contact you and/or leave messages.

Appointment Information	Medical Information
□ Home Phone	□ Home Phone
□ Mobile Phone	□ Mobile Phone
□ Mobile Text**	□ Mobile Text**
□ Work Phone	□ Work Phone
□ With another person:	□ With another person:
□ Send Via Mail	□ Send Via Mail
□ Send Via Email	□ Send Via Email

**Checking the Mobile Phone box will enroll you in Text Message Appointment Reminders. Messages are an automated reminder only and are delivered the night before your appointments with us. Carrier messaging rates apply per your plan.

If you have authorized us to communicate medical or appointment information with another individual, please provide their name and relationship:

Name: _____ Relationship: _____

AGREEMENT INFORMATION

I have read the above information and have authorized Onondaga Physical Therapy to relay appointment or medical information in the manners I have specified above.

x _____

PATIENT SIGNATURE DATE

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Attendance Policy: 24-Hour Notice Required

Avoid a Fee! Send a **TEXT MESSAGE or PHONE CALL to (315) 635-5000** greater than 24-hours in advance to Cancel/Change an appointment ***OR*** Meet with your therapist virtually via Telehealth.

We have reserved these times to care for you. **You are expected to arrive on time to all scheduled appointments** or give 24-hour notice to cancel or change a scheduled appointment. If your **personal or work schedule** might affect your ability to keep an appointment, *please don't schedule until you are certain you can keep your time*. We are sensitive to the fact that an emergency may occur in rare instances and do offer 1 cancellation per month as a courtesy.

Please be considerate of our other patients. We maintain a WAITING LIST so that we can offer open appointments to *other patients waiting to be treated.* For this reason, if you do not give adequate notice & allow us to care for another patient instead, you will be charged for the missed appointment. **This includes late arrivals.** If you arrive more than **10 minutes late,** you will be considered a "no show." **If you fail to show for an appointment** without speaking to our staff, we will call/text you to remind you of your next appointment. If you do not confirm by the next morning, we will **delete all future appointments** to open up opportunities for other patients. You will need to contact us to schedule further appointments.

We do offer TELEHEALTH as a convenient alternative for the in-person visits. Continue with your care in a secure online visit with your therapist. No fees will be assessed for appointments converted to Telehealth.

1st late cancel/No Show per month	*Fee waived*
2nd late cancel/No Show	$25
3rd late cancel/No Show	$50
4th late cancel/No Show	$65

Exceptions may be made for inclimate weather based upon the school districts surrounding each of our offices. In addition, we have a set of guidelines to allow for cancellations related to COVID-19

I agree to abide by the above policy and to **pay the above fee PRIOR to my next appointment** if i am in violation. **I understand these charges will NOT be covered by my insurance company.**

X _____

Printed Name **Signature** **Date**

Therapist Reviewed (Initial): _____