



Empowering patients to live life to the fullest!

Thank you for choosing Ribbons Physical Therapy to assist with improving your health!

Here is some information to make your first appointment run smoothly.

If you have a mask, please wear it into the office. If not, we have masks available.

If you have been in contact with someone who has been exposed to Covid-19, please contact us prior to coming in for your appointment.

We will take your temperature upon entering the office.

Due to Covid-19 virus we are only allowing one other person to accompany you into the office.

If you are unable to keep your appointment, please contact us as soon as possible. This will allow us to accommodate other patients who may be on a waiting list to get seen sooner.

If you have been mailed or emailed paperwork, please bring this with you to the initial appointment along with a photo ID, your insurance card(s), and a list of your medications with dosages. This helps us to maximize your treatment time with the therapist.

We look forward to meeting you soon!

Andrea F. Buchanan Office Manager
Ribbons Physical Therapy
300 Clinchfield St., Ste. 320
Kingsport, TN 37660

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REGISTRATION FORM

NEW PATIENT INFORMATION

Referred by: _____ Today's Date: _____

Patient Name: _____ SSN: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

DOB: _____ SEX: M or F (please circle)

Home Phone: _____ Cell Phone: _____

Present Employer: _____ Work Phone: _____

Emergency Contact: _____

Home/Cell: _____

Relationship _____

INSURANCE

Primary Insurance Name: _____

Policy Number: _____ Group Number: _____

Policy Holder Name: _____

DOB: _____ SEX: M or F (please circle) SSN: _____

Policy Holder Address: _____

Secondary Insurance Name: _____

Policy Number: _____ Group Number: _____

Policy Holder Name: _____

DOB: _____ SEX: M or F (please circle) SSN: _____

Do you want a copy of our Notice of Privacy Practices? Yes/No (please circle)

I voluntarily give consent and permission for Ribbons Physical Therapy, LLC. And its licensed therapists to administer medically necessary therapy services.


Signature: _____ Date: _____

I understand that I am financially responsible for any medical services at the time of service. I authorize my insurance carrier to pay Ribbons Physical Therapy, LLC. Any assigned claims filed by them and authorization for release of medical information requested by my insurance company. For Medicare beneficiaries: I request payment of Medigap benefits be made to me or on my behalf to Ribbons Physical Therapy, LLC. And any medical information about me to be release to my Medigap insurer.

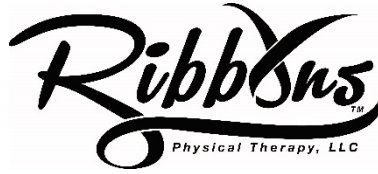
Signature: _____ Date: _____



Patient History

Your Full Name:	Date:
What is the reason for your visit today?	
What is your main goal in coming to therapy?	
Do you have any other symptoms/pain that are related or unrelated to your condition?	
Discomfort Assessment	
Do you have discomfort? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If you answered yes above, please continue with questions below. If you answered no, skip to the *Personal information/Social history section* below.	
Discomfort intensity: On a 0-10 scale (0 being none, 5 = moderate, 10 = worst you can imagine), how would you rate your discomfort; including numbness and tingling?	
Average Discomfort Currently: _____ At its worst _____ At its best: _____	
Is your current discomfort: <input type="checkbox"/> Constant <input type="checkbox"/> Intermittent If intermittent, what percentage of the day do you have discomfort?	
Location of discomfort:	
Describe your discomfort (aching, burning, stabbing, etc.):	
Do you have any of the following symptoms: <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Pins <input type="checkbox"/> Needles <input type="checkbox"/> Limb falling asleep	
If so, what locations of your body?	
What causes your discomfort to increase?	
What relieves your discomfort?	
What time of day is your discomfort worse: <input type="checkbox"/> Morning <input type="checkbox"/> Midday <input type="checkbox"/> Evening <input type="checkbox"/> Night	
Personal Information/Social History	
Hand dominance: <input type="checkbox"/> Right <input type="checkbox"/> Left	
Work Status: <input type="checkbox"/> N/A <input type="checkbox"/> Full Duty <input type="checkbox"/> Retired <input type="checkbox"/> Off because of current injury: How long? _____ <input type="checkbox"/> Work with the following restrictions:	
Duties/Physical Demands at Work:	
Do you currently smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many packs a day ____? For how many years?	
If not, were you a former smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No When did you quit?	
Have you had chemotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, date completed _____	
Have you had radiation? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, date completed _____	
What everyday activities are limited by your current condition (work, driving, laundry)?	
OVER 	

Diagnostic Testing	
Please list any tests you have had for any condition in the last 3 months (x-ray, MRI, PET, CT scan, etc.)	
Please list your current medications with dosages (including supplements and over the counter medications)	
Past Medical History	
Please check current and past medical problems that you have been treated for.	
<input type="checkbox"/> Cancer/Type	Experienced Recurrence of Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Loss of Bowel Control <input type="checkbox"/> Bleeding Problems <input type="checkbox"/> Blood Clots
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Loss of Bladder Control <input type="checkbox"/> Intestinal Disorders
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Headaches <input type="checkbox"/> Epilepsy or Seizures <input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Asthma <input type="checkbox"/> Circulatory Problems <input type="checkbox"/> CVA-Stroke
<input type="checkbox"/> Gout	<input type="checkbox"/> COPD or Emphysema <input type="checkbox"/> Liver Problems/Hepatitis <input type="checkbox"/> Pacemaker
<input type="checkbox"/> Metal Implants	<input type="checkbox"/> Chronic Bronchitis <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Gallbladder Problems
<input type="checkbox"/> Currently Pregnant	<input type="checkbox"/> Kidney Disease/Stones <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Depression/Anxiety
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Parkinson's <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Peripheral Neuropathy
<input type="checkbox"/> Other:	
Past Surgical History	
Please list your previous surgeries and the year you had the surgery.	
Surgery	Year
Additional information:	



No-show and Late Cancellation Policy

Welcome to Ribbons Physical Therapy, LLC. Please take the time to review the following information pertaining to our policy for no show appointments and late cancellations. Please understand that the services we provide are highly specialized and our therapist spends one on one time dedicated to your care.

When you make your appointment, we are reserving a room and a therapist for your individual needs. We ask that if you must change your appointment, please give us at least 24-hour notice. This courtesy makes it possible to schedule your reserved room and therapist time to another patient who is in need.

There is a charge of \$25.00 for not showing up for scheduled appointments. Two cancellations or missed appointments will result in loss of future appointment privileges.

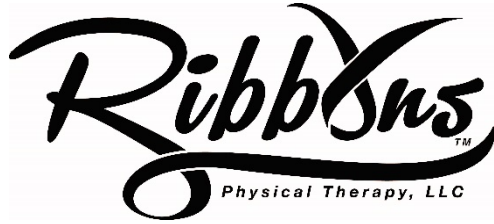
We feel our patient's time is valuable. When your appointment is made, a room and therapist are reserved, your records are prepared, and the necessary equipment is readied for your visit. We try our best to be prompt in getting you back for your scheduled appointment. We, of course, would appreciate the same courtesy from you. If you arrive late for your appointment, your treatment time may be shortened.

Thank you,

Ribbons Physical Therapy Staff

Please sign below as confirmation that you have read, acknowledge and understand our policy regarding no show and late cancellations.

Patient Signature _____ Date _____



Acknowledgement of receipt of Notice of Privacy Practices

Ribbons Physical Therapy, LLC will use and disclose your personal health information to treat you. To receive payment for the care we provide, and for other health care operations, Ribbons Physical Therapy, LLC operations generally includes those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies and about your personal health information. The terms of the notice may change with time, and we will always post the current notice at our facility and have copies available for distribution.

I, _____ (please print name),
have reviewed or received a copy of this facility's Notice of Privacy Practices.

Signature _____ Date _____

I understand that my protected health information will only be verbally communicated to those individuals listed below. Those individuals will be required to provide the last four (4) digits of my Social Security Number, along with my date of birth, before any information will be discussed with them.

List the individuals that you want protected health information verbally discussed with.

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communication barriers prohibited obtaining the acknowledgement

An emergency prevented us from obtaining acknowledgement

Other Please Specify _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. Include completed consent in the patient's Medical Record

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Financial Policy

Thank you for choosing Ribbons Physical Therapy, LLC. We are committed to providing you with the best possible service and ask that you read and acknowledge the terms of our Financial Policy.

PAYMENT: All payments including copay, coinsurance and deductible are due on the date of service. We accept cash, checks, Visa, MasterCard, American Express and Discover credit cards. As a courtesy to our patients, we will contact your insurance provider to verify your physical therapy coverage. We cannot, however, guarantee the accuracy of the information we receive from your insurance provider.

COINSURANCE/DEDUCTIBLE: If you have a plan with coinsurance percentage or deductible which has not been met, we will estimate the coinsurance/deductible amounts based on what we have been led to expect your insurance company will pay. Please note that any payment made on the date of service is considered a **DEPOSIT** toward your **ESTIMATED** patient balance. Because this is an estimate, there is always the possibility that you may be either responsible for an additional balance or due a refund. If a refund is due – it will be promptly provided. If it turns out that your insurance company payment is less than expected – you are responsible to promptly pay any additional balance due. An unpaid balance over 30 days past due may be referred to a collection agency. If your account is turned over to a collection agency, you will be responsible for any costs incurred.

RETURNED CHECK POLICY: Checks deposited by Ribbons Physical Therapy, LLC and then returned by the bank for insufficient funds or any other reason are the responsibility of the patient or patient's guarantor, including any bank fees as applicable.

INSURANCE: We encourage you to call your insurance company with any specific questions related to your policy's outpatient physical therapy benefits such as deductible, copayment, coinsurance, visit limitations i.e., sharing of outpatient benefits with acupuncture, chiropractic or occupational care, effective annual calendar renewal date, or any pre-authorization requirements. Ribbons Physical Therapy, LLC. cannot assume responsibility for incorrect information provided to us concerning your insurance policy. Our courtesy verification of eligibility and benefits does not guarantee that your insurance company will pay for all services provided. Your insurance policy is a contract between you and your insurance company. You are responsible for knowing your level of coverage and are ultimately responsible for the full payment of your bill.

I have read and understand the above Ribbons Physical Therapy, LLC. Financial Policy agree to the terms and understand that I am ultimately responsible for payment of the health care services provided.

Printed Patient Name or Printed Name of Guarantor

Signature of Patient (or Guarantor)

Date _____