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.

As of May 8, 2023, our office no longer requires masking. If you wish to wear a mask, please bring one with you. Also, if you wish for your therapist to wear a mask, please let the front office staff know upon your arrival to the clinic. If you do not feel comfortable waiting in our waiting area with everyone not masking, please call the office to discuss prior to your appointment.

If you are receiving home health, we will need to reschedule your appointment after you have completed your treatment. Insurance will not cover home health and outpatient therapy at the same time.

Please inform us if you are a lymphedema patient and are experiencing any weeping from the affected area or have any open wounds.

If you are unable to keep your appointment, please contact us at least 24 hours in advance. 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), a current list of medications including supplements and dosage and any surgical history. This helps us to maximize your treatment time with the therapist. If you have not completed your paperwork, please arrive 30 minutes prior to your scheduled appointment to complete your New Patient Packet with medications included. If paperwork is not completed by your scheduled appointment time, you may be asked to reschedule.

We look forward to meeting you soon!

Ribbons Physical Therapy
300 Clinchfield St., Ste. 320
Kingsport, TN 37660
(423) 251-4742

Ribbons Physical Therapy
508 Princeton Rd, Ste. 305
Johnson City, TN 3601
(423) 251-4742

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) Marital Status: S M D W (please circle)

Home Phone:_____ Cell Phone:_____

Email Address: _____

Present Employer: _____ Work Phone: _____

Emergency Contact: _____Relationship_____ Home/Cell: _____

How did you hear about Ribbons Physical Therapy? _____

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 released 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 Physical Therapy?
Do you have any other symptoms/pain that are related or unrelated to your condition?
Discomfort Assessment
Do you have discomfort? □ Yes □ No
If you answered yes above, please continue with questions below. **If you answered no, skip to the personal/social history section.**
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: □ Constant □ 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: □ Numbness □ Tingling □ Pins □ Needles □ 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: □ Morning □ Midday □ Evening □ Night
Personal Information/Social History
Hand dominance: □ Right □ Left
Work Status: □ N/A □ Full Duty □ Retired □ Off because of current injury: How long? □ Work with the following restrictions:
Duties/Physical Demands at Work:
Do you currently smoke? □ Yes □ No If yes, how many packs a day ___? For how many years?
If not, were you a former smoker? □ Yes □ No When did you quit?
Have you had chemotherapy? □ Yes □ No If so, date completed_____
Have you had radiation? □ Yes □ 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 (including supplements and over the counter medications)			**Dosage**
Past Medical History			
Please check current and past medical problems that you have been treated for.			
□ Cancer/Type: _____ Experienced Recurrence of Cancer □ Yes □ No			
□ Osteoarthritis	□ Loss of Bowel Control	□ Bleeding Problems	□ Blood Clots
□ Diabetes	□ Rheumatoid Arthritis	□ Loss of Bladder Control	□ Intestinal Disorders
□ Heart Disease	□ Headaches	□ Epilepsy or Seizures	□ High Blood Pressure
□ Osteoporosis	□ Asthma	□ Circulatory Problems	□ CVA-Stroke
□ Gout	□ COPD or Emphysema	□ Liver Problems/Hepatitis	□ Pacemaker
□ Metal Implants	□ Chronic Bronchitis	□ Thyroid Problems	□ Gallbladder Problems
□ Currently Pregnant	□ Kidney Disease/Stones	□ Multiple Sclerosis	□ Depression/Anxiety
□ Tuberculosis	□ Parkinson's	□ Fibromyalgia	□ Peripheral Neuropathy
□ 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 of 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 reserve a room and a therapist for your individual needs, typically for one hour. 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. **We ask that if you must change your appointment, please give us at least 24 hours' notice.** This courtesy makes it possible to schedule your reserved room and therapist's time for another patient who is in need. When you cancel on short notice or do not show up for your appointment, we lose that hour and are unable to schedule another patient. In addition, as a result of your cancellation your therapist may **NOT** be paid during that hour.

- ***Therefore, after 1 cancellation without ample notification will result in a $25 fee and may result in loss of future appointment privileges.***
- ***There is a charge of $50.00 for not showing up for scheduled appointments and may result in loss of future appointment privileges.***
- If you arrive late for your appointment, your treatment time may be shortened.
- **Home Health:** If you are receiving any home health services, please contact our office to reschedule or cancel your visits. Insurance will not cover home health services and outpatient services at the same time.

Thank you,

Ribbons Physical Therapy, LLC

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

Patient Signature_____ **Date** _____

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

_____ **Date**_____

Signature of Patient (or Guarantor) 7/22

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.

V6/23