



PATIENT REGISTRATION

Name: _____ Date: _____

Address: _____

City: _____ State _____ Zip Code: _____

Cell Phone Number: _____ Home Phone: _____

Date of Birth: _____ SS# _____

Sex: Male or Female: _____

Email: _____

Today's Visit is a Result: Work Injury Auto Accident Date of Accident: _____
 Other: _____

Health Insurance Yes No Pregnant Yes No

Employer Information

Name: _____ Phone: _____

Address: _____

Supervisor: _____

Emergency Contact:/Spouse _____ Phone: _____

TRANSFER OF BENEFITS FROM INSURANCE AND RELEASE OF INFORMATION AUTHORIZATION
 I certify that I am or my dependent (s) have/has (n) coverage with_____. I authorize transfer of benefits to RNS Physical Therapy. I understand I am financially responsible for ALL charges incurred whether or not paid by insurance. I authorize use of my signature on all insurance claims.

RNS Physical Therapy may use my health information and may disclose this information to insurance carriers(s) assigned to my claim to determine benefits related to my treatment and as well obtain payments for services rendered.

This authorization will end when current treatment plan is completed or when account is paid in full.

By signing this patient registration you authorize treatment and acknowledge the above statement.

X _____ Date: _____

Who Referred You to RNS Physical Therapy: _____

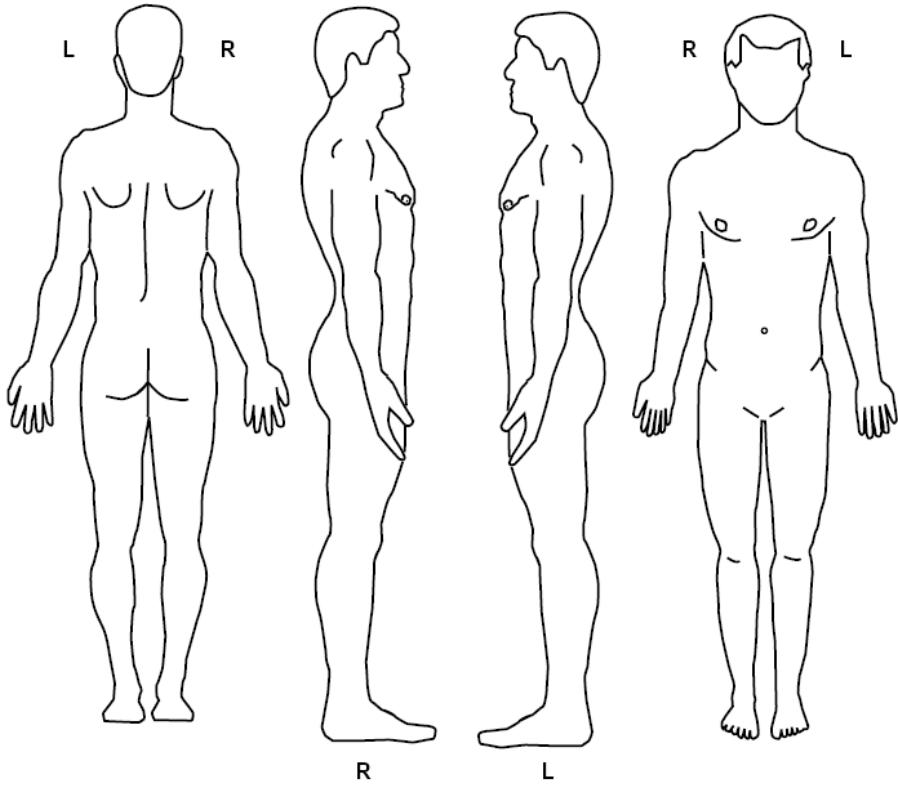
Aurora Location: 645 E. New York Street Aurora, IL 60505 (630)375-1604
 Chicago Location: 4341 S. Archer Ave., Chicago, IL (773)579-0520

Where Your Health Improves – Donde Su Salud Mejora

Name _____ Date: _____

Please be sure to fill this out extremely accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate symbol(s), mark areas of radiating pain, and include all affected areas. You may draw in the face as well.

Numbness ----- Pins & oooooo Burning xxxxxxxx Stabbing ////////////// Aching (((((((((
 ----- Needles ooooooo Pain xxxxxxxx Pain ////////////// Pain (((((((((



Please mark on the line the pain level that most accurately represents your pain:

NO PAIN:	0	1	2	3	4	5	6	7	8	9	10	UNBEARABLE PAIN
a) Right Now:----	0	1	2	3	4	5	6	7	8	9	10	_____
b) Average Pain	0	1	2	3	4	5	6	7	8	9	10	_____
c) At Best -----	0	1	2	3	4	5	6	7	8	9	10	_____
d) At Worst-----	0	1	2	3	4	5	6	7	8	9	10	_____

Aurora Location: 645 E. New York Street Aurora, IL 60505 (630)375-1604

Chicago Location: 4341 S. Archer Ave., Chicago, IL (773)579-0520

Where Your Health Improves – Donde Su Salud Mejora



Patient Acknowledgement

For use and/or disclosure of Protected Health Information (PHI)

To carry out Treatment, Payment and Healthcare Operations

By signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. The Practice's "Notice of Privacy Practices" is also provided in the practice waiting room. I may also request a copy from this office at any time via US Mail.
4. This Notice of Privacy Practices also describes my rights and the duties of this office **with** respect to my protected health information.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Printed)

Signature of Individual

Aurora Location: 645 E. New York Street Aurora, IL 60505 (630)375-1604

Chicago Location: 4341 S. Archer Ave., Chicago, IL (773)579-0520

Where Your Health Improves – Donde Su Salud Mejora