PROGRESSIVE BEGINNINGS
920-803-1617 Rehabilitation Specialists

2131 S Business Drive Sheboygan, WI 53081
P: (920) 803-1617 F: (920) 803-1622

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name (Last, First, MI):_____

Sex: M F DOB (mm/dd/yyyy): _____ Social Sec Num:_____/_____/_____

Address:_____ City:_____ State:_____ ZIP:_____

Phone: (___)_____ EMAIL:_____

Would you like reminders of upcoming appointments? Circle one: TEXT or EMAIL

RESPONSIBLE PARTY IF OTHER THAN SELF:

Name (Last, First, MI):_____Relationship to patient:_____

Sex: M F DOB (mm/dd/yyyy): _____ Social Sec Num:_____/_____/_____

Address:_____ City:_____ State:_____ ZIP:_____
(If same as patient as patient leave blank)

Phone: (___)_____ EMAIL:_____

Name (Last, First, MI):_____Relationship to patient:_____

Sex: M F DOB (mm/dd/yyyy): _____ Social Sec Num:_____/_____/_____

Address:_____ City:_____ State:_____ ZIP:_____
(If same as patient as patient leave blank)

Phone: (___)_____ EMAIL:_____

HISTORY INFORMATION:

-What **area(s) of your body** is/are affected? _____

-What words would you use to describe your pain? _____

-Rate the pain for your PRIMARY location: 1 2 3 4 5 6 7 8 9 10

-Why do you think you are still experiencing pain? _____

-What makes your pain WORSE?

Please circle: SITTING, STANDING, LYING DOWN, BENDING, REACHING, LOOKING UP, INACTIVITY, PROLONGED ACTIVITY, TURNING HEAD, ROLLING IN BED, WALKING,
OTHER: _____

-What makes your pain BETTER?

Please circle: HEAT, ICE, MASSAGE, PRESCRIPTION MEDS, OVER THE COUNTER MEDS, SLEEPING, SITTING, REPOSITIONING, RELAXATION, RESTING, OTHER: _____

-**MEDICATIONS**:_____

_____

-Are you currently taking blood thinning or anticoagulant medications for any medical conditions? **Yes** **No**

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Name: _____ DOB: _____ Today's Date: _____

PATIENT REGISTRATION FORM

HISTORY INFORMATION CONTINUED

-**ALLERGIES**: _____ Are you latex sensitive? **Yes** **No**

-Previous **surgeries**? Please describe:

_____

_

-Do you have resuscitation orders? **Yes** **No** If yes, please provide a copy of the orders

-Have you fallen in the past 6 months? **Yes** **No** Have you fallen in the past 1 year? **Yes** **No**

-Have you received therapy before? YES NO When and what for? _____

-Have you RECENTLY experienced any of the following (check all that apply)?

- ❑ Changes in bowel or bladder function
- ❑ Nausea/vomiting
- ❑ Dizziness/lightheadedness
- ❑ Difficulty maintaining balance
- ❑ Weight loss/gain
- ❑ Shortness of breath
- ❑ Headaches
- ❑ Changes in appetite
- ❑ Fever/chills/sweats
- ❑ Pain at night
- ❑ Weakness/fatigue
- ❑ Difficulty swallowing

-Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ Anemia
- ❑ Anxiety disorders
- ❑ Asthma
- ❑ Cancer (type_____)
- ❑ Chemical Dependency
- ❑ Dementia
- ❑ Depression
- ❑ Diabetes
- ❑ Epilepsy/ seizure disorder
- ❑ Fibromyalgia
- ❑ Heart Disease
- ❑ High blood pressure
- ❑ Kidney/liver problems
- ❑ MRSA
- ❑ Multiple Sclerosis
- ❑ Obesity
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Pacemaker inserted
- ❑ Parkinson's disease
- ❑ Psychiatric disorders
- ❑ Pulmonary disease
- ❑ Rheumatoid Arthritis
- ❑ Stomach Ulcers
- ❑ Stroke
- ❑ Thyroid problems
- ❑ Other _____

FUNCTIONAL ABILITIES:

-How long are you able to maintain standing, for example, to shower, make lunch, etc? _____

-How long would you like to be able to stand for? _____

-How long are you able to walk? _____

-How long would you like to be able to walk for? _____

-Do you use an assistive device? YES NO What? Cane, 2 wheeled Walker, 4 Wheeled Walker, Other: _____

-Are you able to go up and down stairs? YES NO Do you use a railing? YES NO

-What are your goals for therapy?

1. _____

2. _____

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PATIENT SERVICES AGREEMENT

PATIENT NAME:_____ DOB:_____/_____/_____

Please initial each policy demonstrating your understanding and consent.

1. ___I authorize Progressive Beginnings, LLC to bill my insurance company directly for the covered portion of charges, and I authorize payment of benefits directly to Progressive Beginnings, LLC. I authorize Progressive Beginnings, LLC to release medical or other information necessary to process claims. I agree to pay my deductible, coinsurance or copayment, and any charges not reimbursed by my insurance carrier. **All copayments are due at the time of service.** Outstanding amounts, including deductibles are payable and due within 30 days of receipt.

2. ___It is the patient's responsibility to inform Progressive Beginnings, LLC of any and all changes in insurance information or coverage. Failure to do so could result in the patient being 100% responsible for all therapy charges.

3. ___If an emergency should occur during treatment, we will contact 911, Sheboygan Pediatric Associates, and the patients primary medical doctor, unless a certified copy of a DNR order has been given to Progressive Beginnings, LLC

4. **___HEALTH POLICY: If the patient is sick and/or contagious within 24 hours of a scheduled appointment, please stay home and do not bring the potential infection into the clinic.**

5. **___**I have been offered or received the NOTICE OF PRIVACY PRACTICES from PROGRESSIVE BEGINNINGS, LLC.

6. **___CANCELATION POLICY:** An agreement has been made between therapist and patient as to the frequency of rehabilitation services in order to maximize the therapeutic effect of treatment. If an appointment must be canceled, we request you call Progressive Beginnings **at least 24 hours** prior. **After 3 CANCELATIONS, the patient will be placed on a schedule-based-on-availability list. This will require the *patient to call for an appointment on each day* he/she would like to receive therapy. We will do everything possible to accommodate you as space on the schedule permits.**

7. **___ NO SHOW POLICY:** TWO consecutive NO SHOWS will result in the cancelation of all remaining scheduled appointments and patient will be discharged.

For our pediatric patients (adults may leave section below blank):

1. ___It is a courtesy of Progressive Beginnings, LLC to allow parents/legal guardians to leave the premises during the appointment of a minor child. If leaving the premises, you must have a contact cell phone on file. You must return to the premises no later than 10 minutes prior to the scheduled end of your child's therapy session.

2. __Children cannot be left unattended in the waiting room. All children and guardians must wait in the reception area until a therapist has arrived to start the session. Children are also not permitted to wait outside for their ride to arrive.

PATIENT/GUARDIAN SIGNATURE: _____ Date:_____/____/_____

LICENSED THERAPIST: _____ Date:_____/____/_____

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AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH CARE INFORMATION

PERSON WHOSE INFORMATION IS AUTHORIZED TO BE USESD OR DISCLOSED:
Name (Last, First, MI): _____
Sex: M F DOB (mm/dd/yyyy): _____ **Social Sec Num:**_____/_____/_____

Person or entity authorized to use or disclose information NAME:_____ ORGANIZATION:_____ ADDRESS:_____ City/State/Zip:_____	**Person or entity authorized to use or disclose information** **PROGRESSIVE BEGINNINGS, LLC** **2131 S BUSINESS DRIVE** **SHEBOYGAN, WI 53081** **(920) 803-1617**
Person or entity authorized to use or disclose information **PROGRESSIVE BEGINNINGS, LLC** **2131 S BUSINESS DRIVE** **SHEBOYGAN, WI 53081** **(920) 803-1617**	Person or entity authorized to use or disclose information NAME:_____ ORGANIZATION:_____ ADDRESS:_____ City/State/Zip:_____

I authorize the following information to be used or disclosed:	**Reason or Purpose for use or Disclosure (Check all that Apply):**
_____Therapy Evaluations _____Medical Evaluations/Physical Exams _____Progress Notes/Staffing Notes/Daily Notes _____Discharge Summary ____ School Academic Records/IEP/IFSP ____ Other (specify) _____	___ At my Request ___ Further Medical Care ___ Coordination of Services ___ Other (specify): _____

AUTHORIZATION

- This authorization is good for one calendar year from the date signed below
- I understand that if I refuse to sign, this will not interfere with my treatment or eligibility.
- The information that I authorize to be released may be redisclosed by the recipient of the records only if allowed by law. If information is redisclosed, the recipient of the redisclosed information may be controlled by different laws
- I have read this form and understand the contents contained within. I agree that a photocopy or facsimile of this form is as valid as the original. This form accurately reflects my wishes and I authorize the use and disclosure of the information described on this form
- I am (check one) _____the person _____the authorized representative of the person, whose information is authorized to be used or disclosed.

SIGNATURE:_____ **Date:**_____/_____/_____
If signed by person other than client, state name and relationship:

Name:_____ **Relationship to Client:**_____