Outpatient Registration Form

Today's Date:	Last Name:	First Name:	Middle Init.	Gender

Maiden Name:	DOB:	Marital Status:	Race/Ethnicity:	Religion:

Social Security #:	Primary Care Physician:	What language do you wish to discuss your healthcare in?

Home Address	Apt #	City	State	Zip Code

Home Telephone #	Cell Phone #	Email Address _____ ☐ Check this box if you DO NOT want to be contacted via email regarding our services.

Employer's Name: _____ *(Please check which applies)* ☐ FT ☐ PT ☐ Unemployed ☐ Retired ☐ Student	Employer's Telephone #

Primary Ins Holder/Sponsor's name and relationship:	Insurance company:
Date of Birth:	Holder/Sponsor's SSN:
Secondary Ins Holder/Sponsor's name and relationship:	**Insurance company:**
Date of Birth:	Holder/Sponsor's SSN:
Third Ins Holder/Sponsor's name and relationship:	**Insurance company:**
Date of Birth:	Holder/Sponsor's SSN:

Emergency Contact Name	Relationship	Home Telephone #	Cell Phone #

Emergency Contact Employer's Name	Work Telephone #

Bon Secours Physical Therapy

Name: _____ **DOB:** _____

Have you had **surgery** for your condition? ◯ **Y** ◯ **N** If yes, please give date(s):_____

Have you had **injections** for your condition? ◯ **Y** ◯ **N** If yes, please give date(s):_____

Please list any **diagnostic tests** you have had for this condition: _____

Have you previously had, or are you currently receiving, any of the following services for your condition: physical therapy, chiropractic care, acupuncture, massage or personal training? ◯ **Y** ◯ **N**

What are your current symptoms? _____

_____

Where is your pain or problem located? _____

_____

When did the injury or symptoms occur? _____

How did the injury or problem occur? _____

_____

Please rate your pain using a 0-10 scale (0 = no pain, 10 = the worst pain you can imagine)

Worst pain since onset _____ **Lowest** pain since onset _____ **Today's** pain _____

Is your pain? ◯ **Constant** ◯ **Intermittent**

What makes your pain/problem **better**? _____ **Worse**? _____

Is there pain present at night? ◯ **Y** ◯ **N** What position helps you sleep? _____

*** What do you hope to accomplish with therapy?** _____

_____

Therapist's comments: _____

_____

Have you had any recent **falls** (within past 3 months) ◯ **Y** ◯ **N** If yes, when? _____

Do you worry about falling? ◯ **Y** ◯ **N** Do you have dizziness? ◯ **Y** ◯ **N**

What type of **non-work** activities are you involved in? _____

When are you scheduled to see your doctor again? _____

How would you rate your overall health status (check one) ? ◯ **Poor** ◯ **Fair** ◯ **Good** ◯ **Excellent**

Would you like to speak with someone regarding **abuse or neglect** that you have recently experienced? ◯ **Y** ◯ **N**

Would you like to speak with someone regarding **suicide**? ◯ **Y** ◯ **N**

I consent to be treated in an open gymnasium atmosphere: ◯ **Y** ◯ **N**

If you marked "YES" - if at any time during the course of your therapy you would prefer to be treated in a more private area, please tell your therapist and they will make appropriate accomodations.

Employment History Are you currently working? ◯ **Y** ◯ **N** If no, how many total days of work have you missed? _____

Are your work duties ◯ **Restricted** ◯ **Full** How many hours per week do you work? _____

Who is your employer? _____

What type of work do you do? _____

What critical work duties have been most affected by your problem? _____

To the best of my knowledge and belief, the information I have given is complete and true. Please sign below.

**** Patient Signature:** _____ **Date:** _____ **Time:** _____

Therapist's comments: _____

Therapist signature: _____ **Date:** _____ **Time:** _____

Patient Name: _____ **DOB:** _____

Patient Summary List

Are you allergic to latex? ◯ YES ◯ NO

Do you have any known allergies? (drug or other) ◯ YES ◯ NO **if YES**, please list below:

Allergies or Drug Allergies	Reaction/Symptoms when allergy occurs	For Clinician Use Only If new, initial and date

☐ Check this box if you have brought a listing of your current medications and you will not have to complete the medication list below. Please give your list to our office staff to include in your chart.

☐ Check this box if you are NOT currently taking any medications.

Current Medication List (include OTC and herbal)	Dosage	Frequency	For Clinician Use Only New	D/C	Date/Initials

Medical History (check all that apply)

☐ Heart Disease	☐ Diabetes	☐ Weight change of more than 10 lbs recently	
☐ Fibromyalgia	☐ Tuberculosis	☐ High Blood Pressure	☐ Asthma
☐ HIV/AIDS	☐ Arthritis	☐ Visual Impaired	☐ Epilepsy
☐ Depression	☐ Pacemaker	☐ Hearing Impaired	☐ Cancer
☐ Osteoporosis	☐ Thyroid Problems	☐ Latex Allergy	☐ Scoliosis
☐ Ehlers-Danlos synd.	☐ Alcohol Use	☐ Pregnant	☐ Stroke
☐ Multiple Sclerosis (MS)	☐ Other (please explain):	☐ Tobacco Use	☐ Hepatitis

Additional/New Medical History	If new, Clinician Initial/Date	Surgical/Invasive Procedure History	Date of Procedure	If new, Clinician Initial/Date

**** Patient Signature:** _____ **Date:** _____ **Time:** _____

Therapist signature: _____ **Date:** _____ **Time:** _____

Personal Representative and Information Form

I,_____, authorize Bon Secours Outpatient Rehabilitation Services to release information about my medical care to:

_____ _____
(Relationship)

_____ _____
(Relationship)

I understand that I must notify Bon Secours Outpatient Rehabilitation Services in writing in order to terminate this designation. I also understand that Bon Secours Outpatient Rehabilitation Services is not responsible for information that is re-disclosed by the above named individual(s).

_____ _____ _____
(Patient's signature) (Date) (Time)

Date of Accident/Incident or Onset of Recent Symptoms	**Type of Incident:** ◯ **Auto** ◯ **Work** ◯ **No Accident** ◯ **Other:** _____

Preferred Communication:
◯ No Preference ◯ Do Not Contact ◯ Mail ◯ Phone

Would you like information in reference to financial assistance? ◯ Yes ◯ No

Do you have transportation issues which may prevent you from attending your therapy? ◯ Yes ◯ No

Advanced Directive Information:

Written Living Will for Medical Choices: ◯ Yes ◯ No *if yes*, location: _____

Written Medical Power of Attorney: ◯ Yes ◯ No *if yes*, name and location: _____

_____

Clinic Patient ID sticker

Bon Secours

Patient's Responsibilities

Welcome to Bon Secours Richmond Hope Therapy Center! Thank you for choosing this facility for your rehabilitation. We look forward to serving you with the highest quality of care available. The following information is to help ensure you, and other patients, have an enjoyable therapy experience.

- If you need to **cancel or reschedule an appointment, please call us at least 24 hours in advance** so that we may open that appointment up to other patients.
- It is important for you to be on time for your appointments. **If you are late, your therapy session may be cut short, or we may have to reschedule your appointment.**
- **If you miss three or more appointments,** you may be **discharged from therapy** services and your physician will be notified.
- Your therapist will give you some instructions/exercises for home. **It is important that you follow these instructions to achieve the maximum benefit from therapy.** Your family should be involved in your care if you require assistance at home.
- Periodically and upon completion of your therapy, we will send progress notes to your physician with recommendations. Together, your therapist, your physician and you will decide when you have reached the maximum benefit from your rehabilitation. **Remember: Simply because your physician writes you a prescription for therapy does not guarantee payment from your insurance company.** We must show objective and functional improvement in an appropriate time frame; otherwise, we are mandated to discharge you from therapy.
- Therapy is performed in an open gym setting. Your therapist may use a curtained treatment area or a private treatment room if increased privacy is necessary.
- Please notify your therapist, the front office or another staff member if you are dissatisfied with your level of care so that we may remedy the situation.
- Out of respect for your privacy and that of other patients, please refrain from using your cell phone during your visit.
- **A parent, legal guardian, or designated caregiver is required to be present for all appointments.**

Thank you for giving us the opportunity to serve your rehab needs. We look forward to helping you achieve your goals and providing you excellent care.

Patient Signature Date Time

BON SECOURS
RICHMOND HEALTH SYSTEM
Bon Secours Health System

VIDEO/PHOTO RELEASE FORM

DATE: _____

NAME: _____

☐ Outpatient ☐Intensive ☐ Employee ☐No Thank you ☐ Other _____

The undersigned hereby authorizes and consents to the taking and/or use of photographs, motion pictures, television, and/or sound recordings. These may be used for the following purposes(s) as indicated by a check mark, and for no other purpose(s):

☐ Medical education ☐ Medical research ☐ Medical records

☐ Publication ☐ News Media ☐ Internet

☐ Other _____

Exceptions to full consent are described below:

_____

_____

_____

_____

This consent shall release Bon Secours Richmond Health System, its Board of Directors, employees of Bon Secours Richmond Health System, and members of the Bon Secours Richmond Health System Medical Staff from any and all liability in connection with the taking, use, publication or dissemination of such photographs, motion pictures, television, and/or sound recordings.

_____
Signature (parent or legal guardian if under the age of eighteen years)

_____
Witness

_____
Other (if needed/ MD, photographer,owner, etc.)

Patient Email and Text Message Informed Consent

Bon Secours Health System, Inc. and its affiliates, agents, independent contractors and any "covered entity" or "business associate" (as those terms are defined in the HIPAA Privacy Rule) with which your information may be shared under HIPAA (collectively, "Bon Secours") may communicate with you by e-mail, text message, and/or other forms of unencrypted electronic communication (together, "Electronic Messaging") to the telephone number(s), email address(es) or other locations reflected on your account or as otherwise provided below. This form provides information about Bon Secours' use, risks, and conditions of Electronic Messaging. It also will be used to document your consent for Bon Secours' communication with you by Electronic Messaging.

How we will use Electronic Messaging: Bon Secours may use Electronic Messaging to communicate with you regarding a wide range of healthcare related issues, including:

- reminders of appointments or actions for you to take before an appointment, follow-ups from appointments, and notices about preventive services, treatment options, coordination of your care and other available health services;
- how to participate in patient satisfaction surveys or how to use our secure patient portal (MyChart); and
- information regarding insurance, billing, eligibility for programs/benefits, and account balances.

Bon Secours may use automatic dialers or pre-recorded voice messages when it communicates with you through Electronic Messaging. All Electronic Messaging may be made a part of your medical record.

Risk of using Electronic Messaging: Electronic Messaging has a number of risks that you should consider, including:

- Electronic Messaging can be circulated, forwarded, sent to unintended recipients, and stored electronically and/or on paper.
- Senders can easily misaddress Electronic Messaging and send the information to an unintended recipient.
- Backup copies of Electronic Messaging may exist even after deletion.
- Electronic Messaging may not be secure and can possibly be intercepted, altered, forwarded or used without authorization or detection.
- Electronic Messaging service providers may charge for calls or messages received.
- Employers and online providers have a right to inspect Electronic Messaging sent through their company systems.
- Electronic Messaging can be used as evidence in court.

Conditions for the use of Electronic Messaging: Bon Secours cannot guarantee, but will use reasonable means to maintain, the security and confidentiality of the messages we send. By signing where indicated below, you acknowledge your consent to the use of Electronic Messaging on the following conditions:

- **IN A MEDICAL EMERGENCY, DO NOT USE ELECTRONIC MESSAGING, CALL 911.** Urgent messages or needs should be relayed to us by using regular telephone communication. Non-urgent messages or needs should be relayed to us by using regular telephone communication or our secure patient portal, MyChart.
- Electronic Messaging may be filed into your medical record.

- Bon Secours is not liable for breaches of confidentiality caused by you or any third party.

- You are solely responsible for any charges incurred under your agreement with your Electronic Messaging service provider (for example, on a per minute, per message, per unit-of-data-received basis or otherwise).

Expiration and Withdrawal of Consent: Unless you earlier withdraw your consent, this consent will expire upon the end of your treatment relationship with Bon Secours. You may choose to stop participating in Electronic Messaging at any time by informing Bon Secours in writing as described herein. You further understand that withdrawing this consent will not cause you to lose any benefits or rights to which you are otherwise entitled, including continued treatment, payment or enrollment or eligibility for benefits. To withdraw consent and stop participating in Electronic Messaging, please contact the BSHSI Privacy Officer or your Local Privacy Officer as described in the Notice of Privacy Practices.

Patient Acknowledgement and Agreement: I have read and fully understand this consent form. I understand the risks associated with the use of Electronic Messaging between Bon Secours and me, and I consent to the conditions and instructions outlined, as well as any other instructions that Bon Secours may impose to communicate with me by Electronic Messaging.

I understand that Bon Secours will send Electronic Messaging to those telephone number(s) and email address(es) in my account:

☐ I request to receive text messages
☐ I request to receive email messages

Release. In consideration of Bon Secours' services and my request to receive Electronic Messaging as described herein, I hereby release Bon Secours from any and all claims, causes of action, lawsuits, injuries, damages, losses, liabilities or other harms resulting from or relating to the calls or messages, including but not limited to any claims, causes of action, or lawsuits based on any asserted violations of the law (including without limitation the Telephone Consumer Protection Act, the Truth in Caller ID Act, the CAN-SPAM Act, the Fair Debt Collection Practices Act, the Fair Credit Reporting Act, the Health Insurance Portability and Accountability Act, any similar state and local acts or statutes, and any federal or state tort or consumer protection laws).

Patient (or Authorized Representative) Signature

Sign