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PATIENT REGISTRATION FORM

PATIENT INFORMATION			
Last Name	First Name	Middle Initial	Preferred pronouns: □ She/Her □ He/Him □ They □ Zie/Hir □ Other: _____
Gender at birth □ Female □ Male	Date of Birth _____/_____/_____	Social Security # _____-_____-_____	Primary Language □ English □ Spanish □ Other _____
Billing Address (street # or PO Box) City: State: Zip:			
Secondary Address (street # or PO Box, city, state, zip) *(i.e. temporary/permanent)*			
Home Phone Number	Cell Phone Number	Contact Preference □ Home Phone □ Cell Phone [□] May leave voicemail message □ Email* □ Text*	
Email Address			
* We cannot guarantee the security of messages sent by email or text and by initialing here you consent to using email or text even with the risk that the messages may be intercepted and read by a third party. _____ (initial) You have the right to at any time request that we communicate with you using alternative means or to alternative locations. Please ask for assistance if you are interested in changing your contact preferences.			
Occupation			
Employer			
Emergency Contact Name Relationship		Emergency Contact Phone #	
Primary Care Physician: Do you give Recovia consent to coordinate care with the above Provider Yes □ No □		Referred By: Do you give Recovia consent to coordinate care with the above Provider Yes □ No □	

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INSURANCE INFORMATION

Do you have health insurance? □ Yes □ No *(Skip to Pharmacy Info)*	Primary Plan Carrier Name Primary Plan Carrier Phone Number	Policy #	Group #
Health Insurance effective date	Policy holder □ Self □ Other _____ Name of policyholder _____ Policyholder DOB		Do you have other insurance? □ Yes □ No *(Skip to Pharmacy Info)*
Secondary Plan Carrier Name Secondary Plan Carrier Phone #	Secondary Policy #	Secondary Group #	

PHARMACY INFOMATION

Pharmacy Name:	
Phone Number:	Fax Number (if available):
Address:	

MEDICAL HISTORY

If you are female are you currently pregnant? ☐Yes ☐ No

How would you describe your general state of health? ☐Excellent ☐Good ☐Fair ☐Poor

Please indicate any serious conditions, illnesses, injuries, brain injuries or trauma, and any hospitalizations, along with approximate dates:

Injury/Illness:	Date:
Injury/Illness:	Date:
Injury/Illness:	Date:
Injury/Illness:	Date:

Do you have any allergies (medicines, environmental, food, etc.)?

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Please indicate whether you have been diagnosed with or have a history of any of the following:

☐Diabetes _____ ☐ Heart Disease_____ ☐Stroke _____

☐ Lung Disease _____ ☐Cancer_____ ☐ Seizures _____

☐Live/Kidney Disease _____ ☐ Hepatitis_____ ☐HIV/AIDs _____

☐ Thyroid Cancer _____ ☐Head Trauma _____ ☐ Surgeries _____

Other Medical History:

Please list past prescription medications:

Do you use any of the following? (check the box to indicate)
☐Aspirin ☐Laxatives ☐Antacids ☐Diet pills ☐Birth control pills ☐Implants ☐Injections

Alcohol Consumption: Do you drink alcohol? ☐Yes ☐ No If yes, how frequently?

Tobacco Use: Do you use tobacco? ☐Yes ☐ No If yes, how frequently?

Caffeine: Do you drink caffeinated beverages? ☐Yes ☐ No If yes, how frequently?

Recreational drugs: Do you use recreational drugs? ☐Yes ☐ No

If yes, what do you use and how often?

Date of last medical check-up _____ physical _____ blood work _____

Have you ever attempted suicide? ☐Yes ☐ No

Have you ever been given a psychiatric diagnosis? ☐Yes ☐ No
If yes, describe your diagnosis:

List hobbies:

Do you exercise regularly? ☐Yes ☐ No If yes, what do you do for exercise and how often?

What is your current living situation?

Do you feel safe there? ☐Yes ☐ No

How would you describe the emotional climate of your home?

What aspects of your life do you consider stressful?
☐Work ☐School ☐Home ☐Other:

How well do you handle the above stressors?

Can you drive independently? ☐Yes ☐ No

Do you have reliable transportation? ☐Yes ☐ No

Highest level of education completed:

Are you currently employed? ☐Yes ☐ No
If not, what are the barriers to employment?

Is there anything that you feel is important that has not been covered?

FAMILY HISTORY

Please indicate if a close relative (parent, grandparent, aunt/uncle, sibling) has had any of the following: – please write relative(s) next to the item (i.e., "aunt – mother's side")

☐Allergies _____ ☐ Asthma _____

☐Heart Disease _____ ☐ High Blood Pressure _____

☐Cancer _____ ☐ Diabetes _____

☐Depression _____ ☐ Anxiety _____

☐Completed Suicide _____ ☐ Attempted Suicide _____

☐Severe Mental Illness_____ ☐ Other _____

CURRENT MEDICATION LIST

Medication Name	Strength	Frequency

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge I have received a copy of Recovia's Notice of Privacy Practices.

Patient/Legal Representative Signature: _____

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MISSED APPOINTMENTS/LATE CANCELLATIONS

It is very important for you to keep all scheduled appointments. If you are unable to keep an appointment, you must notify us as soon as possible – at least 24-hours before – so we can use those appointment times for other patients. If you do not cancel your appointment within 24 hours' notice, we may charge you a "missed appointment" fee.

CONSENT TO FILM, PHOTOGRAPH AND RECORD

By signing below, I consent to the filming, recording or photographing of me for the purposes of identification, treatment and for Provider's internal operations, such as quality improvement and educating students and professionals. I understand I will not receive any compensation for any such films, recordings, or photographs.

NOTICE OF HEALTH INFORMATION PRACTICES

I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding Recovia, LLC's participation in the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

Patient Signature_____

CONSENT FOR EVALUATION AND TREATMENT AND AGREEMENT OF FINANCIAL RESPONSIBILITY

By signing below I am authorizing and consenting to all evaluation, care and treatment provided by Recovia, Recovia PT and its affiliated health care providers, which may include students, residents, volunteers and other trainees. Through this consent, I am authorizing all evaluation and care, including medical and behavioral health care, psychotherapy, physical therapy, occupational therapy, radiologic and diagnostic examinations, laboratory procedures and tests, and substance use disorder treatment services, including those requested or ordered by my health care provider. I understand that I may refuse services from a student, resident or trainee. I understand that I must undergo an initial evaluation to include a full biopsychosocial evaluation to include any or all of the following; medical, behavioral health and physical therapy before being accepted as a Recovia patient and that this evaluation is not intended to, and will not, provide a medical diagnosis or guarantee my admission to the program. I will be informed of my acceptance into the program after undergoing evaluation. If at any time I choose to terminate my evaluation prior to completion my insurance will be billed appropriately.

I authorize Recovia and Recovia PT to submit claims for services rendered to my health insurer(s), including, Medicare, Medicaid, or other insurance company, and assign benefits payable for my services to Recovia, including but not limited to, health insurance, liability insurance, Workers' compensation, employer and other third party benefits. I understand that I am responsible for and agree to pay all amounts not paid for by my insurer(s), including applicable co-payments, coinsurance and/or deductible amounts and amounts for non-covered or denied services. I understand that co-payments are only an estimate of charges and may be found to be insufficient after review by my insurer(s). If my insurer pays me directly for services rendered by Recovia, I will provide Recovia with copies of the insurer's "Explanation of Benefits" and forward all payments received from my insurer to Recovia immediately upon receipt. If my insurance company does not make payment to Recovia within 60 days, I understand that I will be responsible for paying Recovia directly and seeking reimbursement from my insurance company at that time.

If you would prefer that Recovia not bill your health insurance or insurer directly and not submit health information to your insurer, please initial in this box [ ]
In this case Recovia will bill you directly and you will be responsible for all charges for services rendered to you by Recovia.

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By signing below, I agree that all of the information that I have provided above is true and accurate to the best of my knowledge, that I have read and understand this form, that all of my questions have been asked and answered, that I consent to receive evaluation and treatment and to comply with the Recovia policies governing the services provided. I understand that my continued consent and compliance with these policies are a prerequisite to my receiving and continuing services with Recovia and Recovia PT. I have been provided a copy of the Provider "Patient Rights and Responsibilities" and acknowledge I have the responsibility to be involved in my care. I understand that psychotherapy, physical therapy, occupational therapy, medications, at home exercise regimens, and medical and behavioral health assessments have benefits and risks. I understand that while treatment often leads to reductions in physical pain and feelings of distress, discomfort and negative emotions, it may also involve discussing unpleasant or painful feelings. I also understand that there is no guarantee regarding my personal therapeutic process. I understand that my personal commitment to my therapeutic process is vitally important to a successful outcome. I also understand and agree to my financial responsibility as outlined above. I am signing this consent for treatment and financial responsibility agreement form willingly and voluntarily.

Patient/Legal Representative Signature: _____ Date: _____

Print Name: _____

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Authorization to Release Protected Health Information

Patient Name: _____ DOB: _____

I HEREBY AUTHORIZE RECOVIA, LLC AND RECOVIA PHYSICAL THERAPY, LLC TO RELEASE INFORMATION FROM MY MEDICAL RECORD TO my referring provider/source, providers involved in my care outside of Recovia, family, friends and other 3rd parties:

NAME/MEDICAL GROUP	PHONE/FAX NUMBER	RELATION/PROVIDER
_____	_____	_____
_____	_____	_____
_____	_____	_____

THE PURPOSE OF THIS DISCLOSURE IS FOR:

☐ Medical Care ☐ Attorney Review ☐ Personal Use ☐ Research ☐ Payment
☐ Other: _____

INFORMATION TO BE RELEASED

☐ All Medical Records/Information ☐ Billing Records/Information ☐ Correspondence
☐ Treatment plan ☐ Medications ☐ Progress notes ☐ Nursing notes ☐ Orders
☐ Consult records ☐ Therapy records ☐ Records or results of UDS testing
☐ Information related to: _____
☐ Other: _____
FOR: ☐ Dates of Treatment: _____ to _____ OR ☐ All Dates of Service

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Substance Use Disorder (Alcohol/ Drug Abuse) Treatment/Referral
☐ Mental Health (Other than Psychotherapy Notes)
☐ HIV/AIDS-related Treatment
☐ Communicable Diseases
☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

I understand that my health information may be protected by federal privacy regulations. I understand that the information used or disclosed, except for my Substance Use Disorder Information under 42 CFR Part 2 (if applicable to my records and information), may be subject to re-disclosure by the person or class of persons or facilities receiving it and would then no longer be protected by federal privacy regulations. I understand that I may revoke this authorization at any time except to the extent that Recovia has already taken action in reliance upon it. I understand that in order to revoke this authorization, I must do so in writing and present my written notice to Recovia, Attn: Medical Records, 337 E Coronado Rd, STE 201, Phoenix, AZ 85004. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization expires one year from the date of signature. A photocopy or scanned signature shall have the same force and effect as the original.

_____ _____
Signature of Patient or Patient Representative and Relation Date