Shea Physical Therapy | Hand Therapy Services OF CORPUS CHRISTI

A MEMBER OF THE CONFLUENT HEALTH FAMILY

Patient Registration Form – Medicare

Patient Name:	Preferred:
Address, City, State, Zip:	
DOB:	Social Security #:
Email Address:	
Home Phone:	Appointment Reminder Method
Cell Phone:	☐ Home Phone ☐ Cell Phone
Work Phone:	☐ Work Phone ☐ Email
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Partner's Name:
Financial Responsibility: ☐ Self ☐ Other, Please List:	
2nd Contact Name/Address:	
2nd Contact Phone:	Relation:
General Physician:	Referred By:
Have you had Physical Therapy treatment since January of this year? ☐ Yes ☐ No	If yes, # of Visits:
Have you had Chiropractic treatment since January of this year? ☐ Yes ☐ No	If yes, # of Visits:
Have you had Home Healthcare in the last 30 days? ☐ Yes ☐ No If yes, Home Healthcare Provider:	

INSURANCE INFORMATION Please Note: A copy of your insurance card(s) will be kept on file. The patient is responsible for providing their most current insurance information.

Primary Insurance:		Secondary Insurance:	
Group #	Policy #	Group #	Policy #
Insured Information:		Insured Information:	

Consent to Treat/Assignment of Benefits/Acknowledgements

I hereby authorize and consent to treatment/services for myself, or on behalf of the above-named patient performed by the staff at Shea Physical Therapy (Shea PT) and/or as directed by my referring provider. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including risk or alternatives to the recommended treatment plan.

I assign payment for these services directly to Shea PT. I authorize the filing of claims to my insurance plan and authorize Shea PT to release necessary health information related to these services to process the claims. I certify that the information I have provided is accurate and complete.

In signing this form, I will promptly pay any required co-pay, coinsurance and/or deductible amounts. I accept that insurance plans may deny payments for what I believe were covered services, resulting in my responsibility for paying for these services.

I acknowledge that I have received the Notice of Privacy Practices, which describes the ways the practice may use or disclose my healthcare information. I understand that my healthcare information may be used for treatment, payment, healthcare operations and other permitted uses or disclosures as described in the Notice.

_____ _____

Signature of Patient/Guardian Date

_____

Print Name and Relationship to the Patient

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Patient name: **DOB:**

Authorization for Communication

By providing my above contact information and signing below, I consent and authorize Shea PT and its related entities, agents, contractors, including but not limited to scheduling, billing, and other departments to use automated telephone dialing systems, SMS text messaging, (if opted in) and electronic mail to (1) provide messages (including prerecorded messages or text messages, (if opted in)) to me about appointment reminders, patient surveys, my account, payment due dates, missed payments, information for or related to medical goods and/or therapy services provided, exchange information, changes to health care law, health care coverage, care follow-up, and other healthcare information or (2) provide messages (including pre-recorded messages) during a call or via text message, (if opted in) that delivers a 'health care' message made by, or on behalf of, a 'covered entity' or its 'business associate' as those terms are defined in the HIPAA Privacy Rule, 45 CFR 160.103. I understand that providing a telephone number and/or email address is not a condition of receiving medical services.

I also understand that I may revoke my consent to contact at any time by directly contacting Shea PT or using the opt-out method that will be identified in the applicable communication. I also understand that it is my responsibility to notify Shea PT immediately of any change in telephone number or email address.

Please check the box below to opt in to receive messaging.

☐ **I consent** to receiving text messages about care, appointment reminders, and important health reminders from Shea PT at the phone number I provided. I acknowledge that my consent is not a condition of purchase. Message & data rates may apply. Message frequency varies. You can reply HELP for support or STOP to opt out of receiving messages. To learn more about how we handle your data please view our privacy policy here.

https://sheaphysicaltherapy.com/wp-content/uploads/sites/8/2026/04/Shea-Website-Privacy-Policy-Terms-11-2025.pdf

☐ **I do not** consent to receiving text messages.

Patient/Guardian Signature: Date:

Release of Information

I hereby authorized Shea PT to discuss my personal healthcare information regarding my treatment including diagnosis/prognosis and/or billing and payment for services rendered on my behalf to the person(s) listed below.

Name (print)	Relationship	Phone number
Name (print)	Relationship	Phone number
Name (print)	Relationship	Phone number

Patient/Guardian Signature: Date:

Patient name:	**DOB:**

Financial Policy

Payment for services is due at the time services are rendered

We will verify your benefits with your insurance carrier. However, this does not guarantee that they will cover the prescribed treatment. By signing below, you are acknowledging that you are responsible for deductibles, copays, coinsurance, and non-covered services not paid by the insurance carrier and understand that you are fully responsible for any balance due for services rendered.

Patient/Guardian Signature: Date:

Cancellation/No Show Policy and Fee Acknowledgement

It is the policy of Shea PT to monitor and manage appointment no-shows and late cancellations. Regular attendance at therapy sessions is crucial for you to recover fully and return to the activities you love. When an appointment is missed, it's a missed opportunity for progress in your recovery, and it impacts our ability to accommodate other patients who may need urgent care.

If you need to cancel or reschedule, please call the clinic.

Scheduled appointments must be cancelled or rescheduled at least 24 hours prior.

Failure to attend your appointment without 24-hour notice may result in a fee of $50 that will be charged directly to you as the patient (not insurance) for each instance of a missed appointment.

Patient/Guardian Signature: Date:

Patient name:	**DOB:**	
MEDICARE SECONDARY PAYER (MSP) FORM		
Part I		
1. Are you receiving benefits under the Black Lung Program? If yes, date benefits began: _____	☐ Yes	☐ No
2. Was this injury/illness due to a work-related accident/condition? If yes, date of injury/illness: _____	☐ Yes	☐ No
3. Was the injury/illness covered under no-fault (and/or medical-payment coverage) including premises or automobile? If yes, date of accident: _____ Is no-fault insurance available?	☐ Yes ☐ Yes	☐ No ☐ No
4. Was this injury/illness related to an accident in which you intend to file liability suit or litigation pending? If yes, please provide: Attorney's Name: _____ Address: _____ Phone Number: _____ If you answered **NO** to all questions, go to Part II. If you answered **YES** to any of the questions above, Medicare is the secondary payer, you do not need to go to Part II. Please provide primary insurance information.	☐ Yes	☐ No
Part II		
1. Are you entitled to Medicare based on? *Check the box that applies* ☐ Age (65 & older) – go to question #2 ☐ Disability – go to question #2 ☐ End Stage – Go to **Part III**		
2. Do you have group health plan (GHP) coverage based on your own current employment, or the current employment of either your spouse or another family member? If yes, based upon if you are 65 & over or disabled, how many employees, including yourself or spouse, work for the employer from whom you have GHP coverage: ☐ Aged (65 & over) - If you are aged and there are 20 or more employees, <u>your GHP is primary.</u> ☐ Disability - If you are disabled and your employer, spouse, or family members employer, has 100 or more employees, <u>your GHP is primary</u>.	☐ Yes ☐ Yes ☐ Yes	☐ No ☐ No ☐ No
Part III		
Medicare benefits are secondary to benefits payable under a GHP for individuals eligible for or entitled to benefits on the basis of ESRD during a period of up to 30-month period if Medicare was not the proper primary payer for the individual on the basis of age or disability at the time that this individual became eligible or entitled to Medicare on the basis of ESRD.		
1. Do you have group health plan coverage?	☐ Yes	☐ No
2. Are you within the 30-month coordination period?	☐ Yes	☐ No
If yes to BOTH questions, GHP is primary during the 30-month coordination period.		
Please provide a copy of your group health insurance if determined to be primary.		
Signature of Patient/Representative:	Date:	
Relationship to Patient:		

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Patient name:	**DOB:**

PATIENT HEALTH QUESTIONNAIRE

Occupation: Height: Weight: Sex: ☐ Male ☐ Female
Leisure Activities/Hobbies:
Are you? ☐ Right-handed ☐ Left-handed
Where do you live? ☐ Private Home ☐ Apartment/Rented Room ☐ Assisted Living/Group Home ☐ Hospice ☐ Other:
With whom do you live? ☐ Alone ☐ Spouse Only ☐ Spouse and Others ☐ Child ☐ Other:
Does your home have? ☐ Stairs, No Railing ☐ Stairs, Railing ☐ Ramps ☐ Uneven Terrain Please explain:
How many times have you fallen in the past 12 months? Did it result in an injury? ☐ Yes ☐ No
During the past month have you been feeling down, depressed, or hopeless or bothered by having little interest or pleasure in doing things? ☐ Yes ☐ No
General Health Status: Please rate your health. ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Please list any known allergies (including medications, latex, etc.) below.

Social History / Wellness	
Do you drink alcoholic beverages? ☐ Yes ☐ No	Do you use tobacco? ☐ Yes ☐ No
How often have you completed at least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your condition? ☐ At least 3 times per week ☐ 1-2 times per week ☐ Seldom or Never	

Surgery / Hospitalization, please include date and reason.	

Please list current medications (including prescription, over the counter, and herbal). You can also provide our office staff a list to copy.

Name	Dosage	Frequency	Please Indicate Route
			Oral Patch Topical Other
			Oral Patch Topical Other
			Oral Patch Topical Other
			Oral Patch Topical Other

Are you currently experiencing any of the following?			
Nausea or Vomiting	☐ Yes ☐ No	Chest Pains (Angina)	☐ Yes ☐ No
Productive/Chronic Cough	☐ Yes ☐ No	Pain Wakes Me at Night	☐ Yes ☐ No
Difficulty Swallowing	☐ Yes ☐ No	Recent Fever, Chills, Sweats	☐ Yes ☐ No
Dizzy Spells	☐ Yes ☐ No	Difficulty Sleeping	☐ Yes ☐ No
Headaches	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Visual Problems	☐ Yes ☐ No	Heart Palpitations	☐ Yes ☐ No
Hearing Loss/Ringing in Ears	☐ Yes ☐ No	Loss of Appetite	☐ Yes ☐ No
Difficulty Walking	☐ Yes ☐ No	Incontinence	☐ Yes ☐ No
Unusual Weakness	☐ Yes ☐ No	Fatigue or Myalgia	☐ Yes ☐ No
Joint Pain or Swelling	☐ Yes ☐ No	Unexplained Weight Changes	☐ Yes ☐ No

Patient name:			**DOB:**
Have you been diagnosed with any of the following?			
Allergies	☐ Yes ☐ No	Hearing Loss	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Alzheimer's	☐ Yes ☐ No	HIV	☐ Yes ☐ No
Hepatitis, If Yes, Type:	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Respiratory Problems	☐ Yes ☐ No	Kidney Disease/Problems	☐ Yes ☐ No
Auto Immune Disease If yes, Type:	☐ Yes ☐ No	Spinal Cord Stimulator	☐ Yes ☐ No
Blood Clots	☐ Yes ☐ No	Vision Problems	☐ Yes ☐ No
Bowel or Bladder Disorder	☐ Yes ☐ No	Osteopenia/Osteoporosis	☐ Yes ☐ No
Cancer, If yes, Site:	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Cardiac Conditions	☐ Yes ☐ No	Parkinson's	☐ Yes ☐ No
Cardiac Pacemaker	☐ Yes ☐ No	Peripheral Vascular Disease	☐ Yes ☐ No
Currently Pregnant	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Dementia	☐ Yes ☐ No	Stroke/TIA	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Speech Problems	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Other:	☐ Yes ☐ No
Fractures	☐ Yes ☐ No	List	

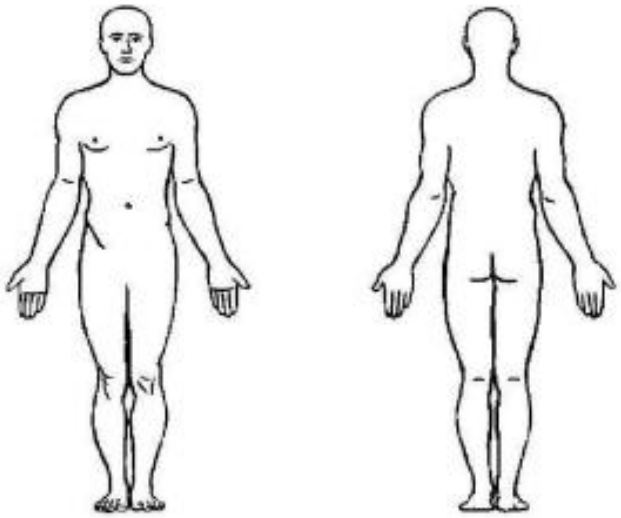
Current Condition
When did this problem(s) first begin/date of onset?
If chronic, when did you seek medical treatment?
Is your current condition related to recent surgery? ☐ Yes ☐ No If yes, specify date of surgery:
Describe the problem(s).
Explain how problem(s) occurred.
Have you ever had this problem before? ☐ Yes ☐ No If yes, how many times?
Are your symptoms worse in the: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Same All Day
How are you taking care of the problem(s) now?
My pain/problem is slowing getting: ☐ Worse ☐ Better ☐ Staying the Same
My symptoms bother me: ☐ Constantly (100%) ☐ Most of the Time (75%) ☐ Occasionally (50%) ☐ Once in a While (25%)
Do you have any numbness, tingling, or burning? ☐ Yes ☐ No If yes, please check one: ☐ Constantly ☐ Intermittently
What functions could you perform before, that you now are unable to do?
Please explain any specific treatment you have received for this problem, such as previous physical or occupational therapy, chiropractic visits, pain medications, etc.
Have you received X-rays, MRI, CT scan, Bone scan for this problem? If so, please list the dates and results.
Are you aware of any physical reason why you should not receive treatment? ☐ Yes ☐ No If yes, please tell us what it is:
What are your goals for therapy?

Patient name: **DOB:**

Symptom Rating

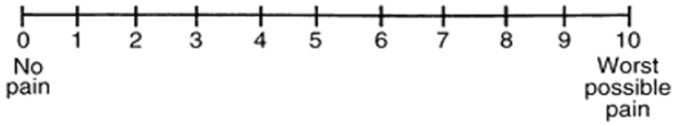
Mark on the body diagram the location of symptom(s):

O - For pain
X - For numbness/tingling/burning



Please rate your pain on a scale from 0 – 10 **(0 = no pain; 10 = Worst pain imaginable)**

Current: /10 Best: /10 Worst: /10



I will advise the therapist if there is any change in my physical condition which will alter my response to any of the questions on this form.

Signature: _____ Date: _____