Patient Registration

Please complete every section and print clearly. Accurate information helps us verify your benefits and bill your insurance correctly. You can type into this form on a computer or phone, or print it and write by hand. Please bring all pages to your first visit.

PATIENT INFORMATION

Last name _____ First name _____ Middle initial _____

Preferred name _____ Date of birth (MM/DD/YYYY) _____ Sex ☐ Female ☐ Male

Mailing address _____ Apt / Suite _____

City _____ State _____ ZIP code _____

Cell phone _____ Home or other phone _____ Email _____

Appointment reminders by: ☐ Text message ☐ Phone call ☐ Email

Preferred language: ☐ English ☐ Spanish ☐ Other: _____

Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Other

Employer _____ Occupation _____

Emergency contact name _____ Phone _____ Relationship to you _____

Clinic: ☐ Cumming ☐ Alpharetta ☐ Either

How did you hear about us? ☐ My doctor ☐ Google ☐ Friend or family ☐ Attorney ☐ Other: _____

REASON FOR YOUR VISIT

Main reason: ☐ Vertigo or dizziness ☐ Balance or falls ☐ Concussion ☐ Neck or back pain ☐ Car accident ☐ Work injury ☐ After surgery ☐ Other: _____

Date it began, or date of injury or surgery _____ Referring or primary care physician _____

Practice name _____ Physician phone _____ Date of last visit with physician _____

INSURANCE

Primary insurance _____ Member ID _____ Group number _____

Policy holder name (if not you) _____ Policy holder date of birth _____ Relationship to patient _____

Secondary insurance _____ Member ID _____ Group number _____

P: (470) 380-7007 · F: 866-851-2493

Patient Registration (continued)

Patient name | Date of birth

CAR ACCIDENT OR WORK INJURY (IF THIS APPLIES)

Claim number | Insurance company and adjuster | Adjuster phone

Attorney and law firm | Attorney phone | Employer at time of injury

OTHER CARE

Are you receiving home health services now? ☐ Yes ☐ No

Have you received home health services in the past 30 days? ☐ Yes ☐ No

Are you receiving physical therapy anywhere else, for any condition? ☐ Yes ☐ No

PARENT OR GUARDIAN (IF THE PATIENT IS UNDER 18 OR HAS A LEGAL GUARDIAN)

Name | Relationship to patient | Phone

PERMISSION TO DISCUSS MY CARE (OPTIONAL)

I give North Atlanta Vertigo & Physical Therapy permission to discuss my appointments, care and billing with the people listed below. I can change or cancel this permission at any time in writing.

Name | Relationship | Phone

Name | Relationship | Phone

Voicemail: ☐ You may leave detailed messages about my care ☐ Please leave only your name and a call-back number

I confirm that the information on this form is accurate and complete, and I will tell the office if any of it changes.

Patient or legal guardian signature | **Date**

P: (470) 380-7007 · F: 866-851-2493

Consent for Treatment and Financial Agreement

CONSENT TO EVALUATION AND TREATMENT

I voluntarily consent to evaluation and treatment by the physical therapists of North Atlanta Vertigo & Physical Therapy (Bodyset Inc.). My care may include a review of my health history; tests of movement, strength, sensation, coordination and balance; eye-movement and positional testing, including infrared video goggles; computerized balance testing; canalith repositioning maneuvers for BPPV; vestibular, balance and gaze-stability exercises; manual (hands-on) therapy; therapeutic exercise; pain neuroscience education; and a home exercise program.

Some tests and treatments for dizziness, such as positional testing and repositioning maneuvers, can briefly bring on vertigo, nausea or unsteadiness, and exercise and hands-on care can cause temporary soreness. My therapist will guard me during balance activities. I will tell my therapist right away if I feel unwell or if anything is too uncomfortable, so it can be changed or stopped. If my dizziness is severe, I will arrange a ride to my visits.

I may ask questions about my care at any time. I understand that I may refuse or stop any test or treatment, and that no specific result can be guaranteed.

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I authorize North Atlanta Vertigo & Physical Therapy to release the medical and billing information needed to process my claims with my health plan, Medicare, auto insurer, workers' compensation carrier or attorney, and to share information about my care with my referring and treating physicians. I assign payment of my insurance and Medicare benefits directly to North Atlanta Vertigo & Physical Therapy for the services I receive. If an insurance payment is sent to me, I agree to forward it to the practice promptly, along with the explanation of benefits.

FINANCIAL AGREEMENT

- I am responsible for my copays, coinsurance, deductibles and any services my plan does not cover. Amounts due are collected at each visit.
- Benefit information I receive is an estimate from my insurance company, not a guarantee of payment. I am responsible for knowing my plan, including visit limits and any referral or authorization it requires.
- Self-pay and out-of-network visits are charged at the practice's flat rate in effect at the time of service and are due at each visit. An itemized receipt (superbill) is available on request.
- If my care is billed to Auto MedPay or under a Letter of Protection, I remain responsible for any charges not paid by my auto insurer or from my claim, settlement or judgment.
- If my care is billed to Workers' Compensation, I will provide my claim and adjuster information. If my claim is denied, I am responsible for charges that are not covered.
- Unpaid balances may be referred for collection, and I may be responsible for reasonable collection costs as permitted by law. A fee may be charged for returned payments.

PRIVACY AND COMMUNICATION

I acknowledge that I have been offered the practice's Notice of Privacy Practices, which explains how my health information may be used and shared and describes my rights. I may ask for a copy at any time. I agree that the practice may contact me by the methods I chose on the registration form, including text message and email, for appointment reminders and messages about my care. Message and data rates may apply, and I may opt out at any time.

By signing below, I confirm that I have read and agree to this consent and financial agreement.

Patient or legal guardian signature	Printed name	Relationship (if not patient)	Date

P: (470) 380-7007 · F: 866-851-2493

Office Policies

APPOINTMENTS AND ATTENDANCE

Every visit is a full 60 minutes, one-on-one with your physical therapist, and that time is reserved only for you. Coming to every scheduled visit is one of the most important parts of your recovery, and a missed appointment is time another patient could have used.

How do I cancel or reschedule? Please call (470) 380-7007 at least 24 hours before your appointment. Cancellations made with less than 24 hours' notice are considered late cancellations.

What is a no-show? A no-show is a missed appointment without any notice.

Is there a fee? A fee may be charged for late cancellations and no-shows. This fee cannot be billed to insurance and is due before your next visit.

Are there exceptions? Yes. If you are ill, have an emergency or feel too dizzy to drive safely, please call us. We may waive the fee, although the missed visit still counts toward the limit below.

What if I miss several visits? After three late cancellations or no-shows within 30 days, we may schedule you only for same-day openings.

What if I am running late? Please call us. If you arrive more than 15 minutes late, we may need to shorten or reschedule your visit, and the late-cancellation fee may apply.

CARD ON FILE (OPTIONAL)

I authorize North Atlanta Vertigo & Physical Therapy to keep my credit or debit card securely on file and charge it for amounts I owe, such as copays or balances remaining after my insurance processes a claim. I will receive a receipt for each charge. I may decline and pay at each visit instead.

To decline keeping a card on file, initial here: _____

PERSONAL BELONGINGS AND CHILDREN

The practice is not responsible for lost or damaged personal items. For safety, children must be supervised and kept off exercise equipment.

By signing below, I agree to these office policies and commit to my plan of care.

Patient or legal guardian signature	Printed name	Date

P: (470) 380-7007 · F: 866-851-2493

Health Questionnaire

Patient name _____ Date of birth _____ Today's date _____

YOUR MAIN CONCERN

What brings you in today?

_____

_____

When did it start? _____ What are your goals for therapy? _____

How did it start? ☐ Suddenly ☐ Gradually ☐ After a fall or injury ☐ Car accident ☐ After an illness ☐ After surgery ☐ No clear cause

Since it started, it is: ☐ Better ☐ About the same ☐ Worse

It is worse in the: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Same all day

DIZZINESS AND BALANCE (SKIP IF THIS DOES NOT APPLY)

My dizziness feels like: ☐ Spinning (vertigo) ☐ Lightheaded or faint ☐ Unsteady or off-balance ☐ Rocking or swaying ☐ Foggy or "off" ☐ Sensitive to motion ☐ Blurred or bouncing vision ☐ Nausea or vomiting

Each episode lasts: ☐ Seconds ☐ Minutes ☐ Hours ☐ Days ☐ It is constant

It is brought on by: ☐ Rolling over in bed ☐ Lying down or sitting up ☐ Looking up or bending over ☐ Turning my head ☐ Standing up quickly ☐ Busy stores or crowds ☐ Screens or scrolling ☐ Nothing specific

Ear and head symptoms: ☐ Hearing loss or change ☐ Ringing (tinnitus) ☐ Ear fullness or pressure ☐ Ear pain ☐ Headaches ☐ History of migraine ☐ Sensitive to light or sound

Have you had a head injury or concussion? ☐ Yes ☐ No Date: _____

Did you lose consciousness? ☐ Yes ☐ No

Have you fallen in the past year? ☐ Yes ☐ No How many times? _____

Are you afraid of falling? ☐ Yes ☐ No

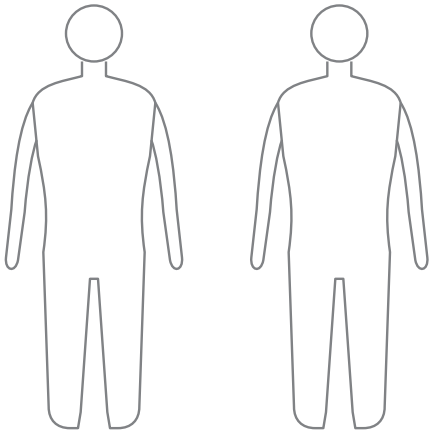
Walking aid: ☐ None ☐ Cane ☐ Walker ☐ Wheelchair ☐ Other: _____

Health Questionnaire (continued)

Patient name _____ Date of birth _____

PAIN (SKIP IF YOU HAVE NO PAIN)

Mark where you feel pain, numbness or tingling.



Front Back

Pain feels: ☐ Sharp ☐ Dull or aching ☐ Burning ☐ Shooting ☐ Throbbing ☐ Numbness ☐ Tingling ☐ Weakness

How often: ☐ Constant ☐ Frequent ☐ Occasional ☐ Comes and goes

Pain from 0 (none) to 10 (worst imaginable):

Now: _____ At best: _____ At worst: _____

Does pain travel into an arm or leg? ☐ Yes ☐ No

DAILY LIFE

Activities or positions that make it worse

Activities or positions that make it better

Daily activities that are hard for you now

Tests you have had for this problem: ☐ X-ray ☐ MRI ☐ CT scan ☐ Hearing test ☐ VNG or balance testing ☐ Blood work ☐ Other: _____

Treatments you have tried (medication, therapy, injections, surgery)

Occupation

Has your work changed because of this problem? (yes / no, how)

IMPORTANT SAFETY CHECK

Check any that you have now. If any of these are new or sudden, call 911 or go to the nearest emergency room. Do not wait for your therapy visit.

- ☐ Sudden, severe headache
- ☐ Trouble speaking or swallowing
- ☐ Fainting or passing out
- ☐ New loss of bladder or bowel control
- ☐ Double vision or loss of vision
- ☐ Weakness or numbness on one side of the body
- ☐ Chest pain or a racing heartbeat
- ☐ None of these

P: (470) 380-7007 · F: 866-851-2493

Medical History and Medications

Patient name _____ Date of birth _____

Check PAST for conditions you have had before and NOW for conditions you have now. This helps your therapist plan safe, effective care.

Past	Now	Condition	Past	Now	Condition
☐	☐	High blood pressure	☐	☐	Osteoporosis
☐	☐	Low blood pressure	☐	☐	Arthritis
☐	☐	Heart disease or heart attack	☐	☐	Rheumatoid arthritis or lupus
☐	☐	Irregular heartbeat	☐	☐	Asthma or COPD
☐	☐	Pacemaker or defibrillator	☐	☐	Kidney disease
☐	☐	Stroke or mini-stroke (TIA)	☐	☐	Hearing loss
☐	☐	Diabetes	☐	☐	Ear surgery or ear infections
☐	☐	Thyroid problems	☐	☐	Ménière's disease
☐	☐	Migraine	☐	☐	Vision problems (glaucoma, cataracts)
☐	☐	Seizures or epilepsy	☐	☐	Previous vertigo or BPPV
☐	☐	Multiple sclerosis	☐	☐	Previous concussion
☐	☐	Parkinson's disease	☐	☐	Neck or back surgery
☐	☐	Neuropathy (numb hands or feet)	☐	☐	Joint replacement
☐	☐	Anxiety	☐	☐	Currently pregnant
☐	☐	Depression	☐	☐	Alcohol or drug dependence
☐	☐	Cancer (type): _____	☐	☐	Other: _____

Height _____ Weight _____ Tobacco use (type and amount) _____ Alcoholic drinks per week _____

Surgeries and hospital stays (with dates)

Medications (include supplements and over-the-counter medicines)

Medication	Dose	How often

Allergies (medications, latex, other)

Patient or legal guardian signature **Date**

For office use: reviewed by _____ Date _____