Patient information:

Name: ____ Age: ________

Date of Birth: _____________________ Marital status: _________________________

Address: ____

City: _________________________________ State: _____ Zip Code: ___________________

Email address: ____

Phone: primary: ______________________ secondary: ____________________

Referring physician: _____________________________________
Employer/school: ____________________________________
Occupation/sport:_______________________________________

Is this injury is due to: an accident? Yes No; auto: yes/no, other: ____________
Is this workers compensation injury? Yes No
Are you currently working? Yes No

Emergency contact: Name: ________________________________ phone:____________________

Have you provided Body Connection Physical Therapy with you insurance information? Primary: Yes No N/A, Secondary: Yes No N/A

How did you hear about Body Connection Physical Therapy: _________________________

Consent to treatment: I give consent for Body Connection Physical Therapy to treat my condition within the scope of practice defined by the American Physical Therapy Association Practice Act and the Licensing Board of the Department of Consumer Affairs. Treatment is administered based on a physician's diagnosis. It is my responsibility to provide Body Connection Physical Therapy with prescriptions as needed. I also understand that if I wish to stop treatment at any time for any reason, I must simply tell my therapist to stop or adjust treatment to my preference.

Assignment of benefits:
I hereby authorize Body Connection Physical Therapy to furnish my insurance carrier(s) any and all requested information concerning my health care. I also authorize my insurance carrier(s) to pay Body Connection Physical Therapy directly for services rendered.

Patient's signature: ____ Date: ___________________

Health Questionnaire

Areas to be treated: ____

____

Date of Injury/onset of pain: ____________ Date of surgery: ____________

Have you ever been diagnosed as having any of the following conditions?

YES NO Cancer. If YES, describe what type and when ________________
YES NO Diabetes Mellitus
YES NO High blood pressure:
YES NO Heart disease
YES NO Stroke
YES NO RA
YES NO Do you have a pacemaker?
YES NO Do you currently smoke cigarettes?
YES NO For women: are you currently pregnant or do you think you might be?

Have you recently noted:

YES NO Fevers/Chills/Sweats
YES NO Unexplained weight loss/gain
YES NO Unusual fatigue
YES NO Nausea/vomiting
YES NO Weakness
YES NO Numbness/tingling
YES NO Dizziness/loss of consciousness
YES NO Changes in bladder/bowel frequency/urgency
YES NO Chest pain/palpitations
YES NO Swelling in feet or hands
YES NO Shortness of breath/Difficulty breathing

Please list your current medications: ______________________________

____

Please list allergies: ____

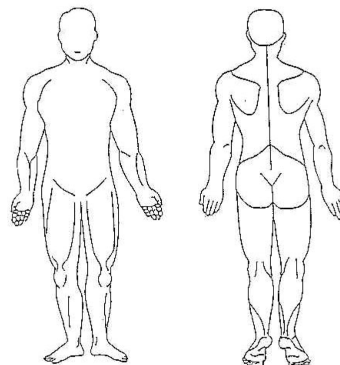
Is there anything significant in your medical history we need to know about?

____

____

Circle your current pain level on average:
No pain 1 2 3 4 5 6 7 8 9 10 max pain

Circle you current pain level at worst:
No pain 1 2 3 4 5 6 7 8 9 10 max pain



We are committed to providing you with the best possible care. In order to achieve this goal, we need your assistance and your understanding of our payment policies.

ALL PAYMENTS ARE DUE AT THE TIME OF SERVICE. WE BILL YOUR INSURANCE AS A COURTESY FOR YOU ON YOUR BEHALF.

Private Health Insurance If you have a co-payment, it is DUE at the time of treatment. We will bill your insurance company. For non-participating insurances, services will be at the reasonable and customary rates. Should you have any questions, we will gladly help you; however, it is your responsibility to know and verify benefits from your insurance company.

______(Initial) I understand that my insurance company will make final determination of payment for services and may be different than benefits verified before my initial evaluation.

Medicare We will bill Medicare for you and will also bill your secondary insurance carrier, if applicable. Medicare pays approximately 80% of the allowed amount and the secondary usually pays the other 20%. There are limits for services that Medicare pays. You will be billed directly for any supplies. If payment is sent to you personally and not our office, you are responsible for any and all portions up to the allowed amount.

Workers Compensation You will be immediately responsible for therapy costs if your workers compensation carrier denies the claim for any reason. Your case manager will be notified of any missing appointments, and may jeopardize your claim. Please contact the office should you need to reschedule your appointment.

To All Patients:

______(Initial) Body Connection PT reserves the right to discontinue treatment if you fail to comply with the policies above. Any returned check for insufficient funds will be assessed a $50.00 processing fee.

______(Initial) Twenty Four (24 Hour) notification is requested when cancelling an appointment. I understand that if I cancel/No show an appointment within 24 hours and another patient cannot use my appointment slot, I will be personally charged a $50.00 late cancel fee.

______(Initial) I have received the Notice of Privacy Practices (HIPPA) and I have been provided an opportunity to review it.

I have read, understand, and agree to the above financial and clinic policies.

Name:_______________(print)Signature:___________________________ Date:_______