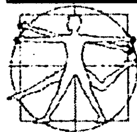


NEW PATIENT REGISTRATION

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	DATE OF INJURY / INJURED AREA	SEX

HOME ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE / CELL PHONE

EMAIL ADDRESS: (PLEASE PRINT)	CELL PHONE CARRIER:

We utilize an automated appointment reminder system that will send a reminder message via email or text, as well as communication to and from out office staff & billing dept. Please confirm your preferred method of communication, and acknowledgment of communication consent: ☐ TEXT TO CELL ☐ EMAIL

INSURANCE CARRIER	INSURED NAME	DATE OF BIRTH	POILICY NUMBER	GROUP NUMBER

REFERRING DOCTOR NAME	REFERRING DOCTOR ADDRESS	REFERRING DOCTOR PHONE
*PRIMARY CARE DOCTOR NAME	PRIMARY CARE DOCTOR ADDRESS	PRIMARY CARE DOCTOR PHONE

EMERGENCY CONTACT OR LEGAL GUARDIAN INFORMATION

NAME	PHONE

RESPONSIBLE PARTY STATEMENT

AS THE RESPONSIBLE PARTY, I AGREE THAT ALL CHARGES THAT ARE NOT DIRECTLY PAID BY MY INSURANCE COMPANY WILL BE MY RESPONSIBILITY.

RESPONSIBLE PARTY PRINTED NAME	RESPONSIBLE PARTY SIGNATURE	TODAY'S DATE

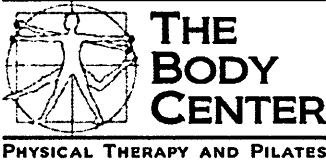
ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE MEDICAL INFORMATION/CONSENT TO TREATMENT

I hereby assign all medical benefits to which I am entitled to the Body Center Physical Therapy, Inc. In the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether paid by said insurance or not paid. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to collection service fees, attorney's fees, and all court costs and additional legal fees associated with the recovery of this debt. Interest may be charged at a rate of 1.5% per month (18% annually) for unpaid balances over thirty days old. If reimbursement is made by other payer sources, i.e. Attorney's, attorney liens, or third party insurances, negotiated insurance discounts will not apply. Payment in full per the clinic's fee schedule is expected. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original.

I do hereby consent to such treatment by the authorized personnel of The Body Center Physical Therapy, Inc. As may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

The Body Center Physical Therapy Inc. is not responsible for any lost, damaged or stolen property on our premises.

AUTHORIZED SIGNATURE	TODAY'S DATE
X	



NEW PATIENT REGISTRATION

Patient Information Consent Form - HIPPA Law

I have read and fully understand The Body Center Physical Therapy Inc.'s notice of information practices. I understand that The Body Center Physical Therapy Inc. may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify The Body Center Physical Therapy Inc. in writing. I also understand that The Body Center Physical Therapy Inc. will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as posted at the front desk. I understand that I retain the right to revoke this consent by notifying The Body Center Physical Therapy Inc. in writing at any time.

Patient Signature ______________________ Date ______________

Internet Photo Release

I grant The Body Center Physical Therapy Inc. the right to take photographs of me for any lawful purpose, including publicity, advertising, social media and other web content.

Patient Signature ______________________ Date ______________

Designated Individuals Authorization

(Anyone other than yourself who will be allowed to pick up your medical records)

I hereby authorize one or all of the designated parties listed below to request, receive and release any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of my information.

Authorized designees:

NAME: ______________________ RELATIONSHIP: ______________________

NAME: ______________________ RELATIONSHIP: ______________________

NAME: ______________________ RELATIONSHIP: ______________________

PATIENT SIGNATURE ______________________ DATE ______________________

Physical Therapy- Patient Health Questionnaire

Patient Name ______________________________ ***Date*** __________

1. Describe your symptoms in your own words: ______________________________

a. **When** did your symptoms start? ______________________________

b. **How** did your symptoms begin? ______________________________

c. What **aggravates** your symptoms? ______________________________

d. What **eases** your symptoms? ______________________________

2. How often do you experience your symptoms?

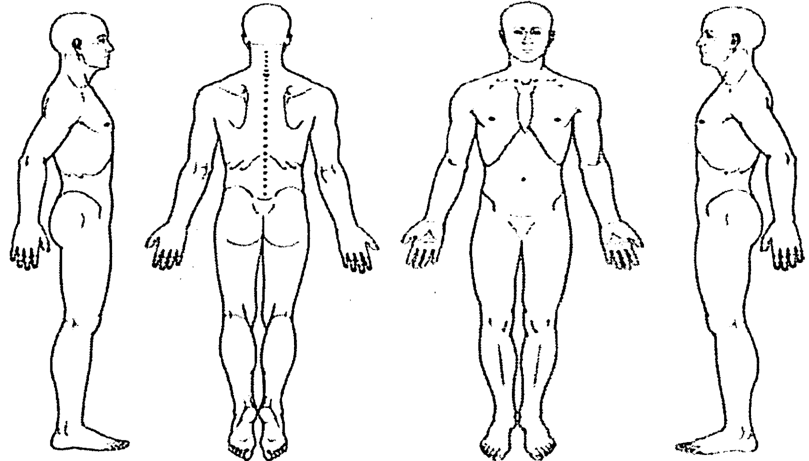
☐ Consistently (76-100% of the day)

☐ Frequently (51-75% of the day)

☐ Occasionally (26-50% of the day)

☐ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the quality of your symptoms?

☐ Sharp ☐ Shooting

☐ Dull ache ☐ Burning

☐ Numb ☐ Tingling

4. How are your symptoms changing?

☐ Getting Better

☐ Not Changing

☐ Getting Worse

5. During the past 4 weeks:

	none										Unbearable
a. Indicate the average intensity of your symptoms	0	1	2	3	4	5	6	7	8	9	10

b. How much has pain interfered with your normal work (including both work outside the home and housework)

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?

(like visiting with friends and/or relatives, or engaging in exercise and/or hobby activates, etc)

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

7. In general would you say your overall health right now is: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

a. What type of regular exercise do you perform? ☐ Strenuous ☐ Moderate ☐ Light ☐ None **[Frequency: ____ per week / month]**

8. Who have you seen for your symptoms? ☐ No One ☐ Medical Doctor ☐ Physical Therapist ☐ Other

a. What treatment did you receive and when? ______________________________

b. What tests have you had for your symptoms and when where they performed? ☐ Xrays date: __________ ☐ CT Scan date: __________ ☐ MRI date: __________ ☐ Other date: __________

c. Key findings from test(s)? ______________________________

9. Have you had similar symptoms in the past? ☐ Yes ☐ No

a. If yes, did the symptoms resolve completely? ☐ Yes ☐ No

10. What is your occupation? ______________________________

☐ Professional/Executive ☐ Tradesman/Laborer ☐ Retired

☐ White Collar/Secretarial ☐ Homemaker ☐ Other

☐ Tradesperson ☐ FT Student ☐ Disability

a. If you are not retired, a homemaker, or a student, what is your current work status?

☐ Full-time ☐ Self-employed ☐ Off work

☐ Part-time ☐ Unemployed ☐ Other

Patient Signature ______________________________ ***Date*** __________

Physical Therapy- Patient Health Questionnaire Page 2

Patient Name ______________________________ ***Date*** ______________________

What are your age, height and weight? Age [ ] years Height [ ][ ][ ] feet inches Weight [ ][ ][ ] lbs BMI: [ ] For office use only

List 1 (one) important activity you are unable or have difficulty performing as a result of your pain/symptoms:

________________________ (ex. Stairs, reaching overhead) 0 1 2 3 4 5 6 7 8 9 10

completely unable … maximum ability

What is your outcome goal with Physical Therapy? ______________________________

____

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	High Blood Pressure	☐	☐	Diabetes
☐	☐	Neck Pain	☐	☐	Heart Attack	☐	☐	Excessive Thirst
☐	☐	Upper Back Pain	☐	☐	Chest Pains	☐	☐	Frequent Urination
☐	☐	Mid Back Pain	☐	☐	Stroke	☐	☐	Smoking/Tobacco Use
☐	☐	Low Back Pain	☐	☐	Angina	☐	☐	Drug/Alcohol Dependence
☐	☐	Shoulder Pain	☐	☐	Kidney Stones	☐	☐	Allergies
☐	☐	Elbow/Upper Arm Pain	☐	☐	Kidney Disorders	☐	☐	Depression
☐	☐	Wrist Pain	☐	☐	Bladder Infection	☐	☐	Systemic Lupus
☐	☐	Hand Pain	☐	☐	Painful Urination	☐	☐	Epilepsy
☐	☐	Hip/Upper Leg Pain	☐	☐	Loss of Bladder Control	☐	☐	Dermatitis/Eczema/Rash
☐	☐	Knee/Lower Leg Pain	☐	☐	Abdominal Pain	☐	☐	HIV/AIDS
☐	☐	Ankle/Foot Pain	☐	☐	Ulcer	***Females Only***		
☐	☐	Jaw Pain	☐	☐	Hepatitis	☐	☐	Birth Control Pills
☐	☐	Joint Swelling/Stiffness	☐	☐	Liver/Gall Bladder Disorder	☐	☐	Hormonal Replacement
☐	☐	Arthritis	☐	☐	Cancer	☐	☐	Pregnancy
☐	☐	Rheumatoid Arthritis	☐	☐	Tumor	☐	☐	____________
☐	☐	Osteoporosis	☐	☐	Asthma	***Other Health Problems/Issues***		
☐	☐	General Fatigue	☐	☐	Chronic Sinusitis	☐	☐	____________
☐	☐	Muscular Fatigue	☐	☐	Disturbances Dizziness	☐	☐	____________
☐	☐	Un-coordinated vision		☐	Allergies ____________			

Indicate if an <u>immediate family member</u> has had any of the following:

☐ Rheumatoid Arthritis ☐ Heart Problems ☐ Diabetes ☐ Cancer ☐ Lupus ☐ __________

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

__________ Dosage: _____mg Frequency: __________ Route: ☐ By mouth ☐ Other:______

__________ Dosage: _____mg Frequency: __________ Route: ☐ By mouth ☐ Other:______

__________ Dosage: _____mg Frequency: __________ Route: ☐ By mouth ☐ Other:______

__________ Dosage: _____mg Frequency: __________ Route: ☐ By mouth ☐ Other:______

__________ Dosage: _____mg Frequency: __________ Route: ☐ By mouth ☐ Other:______

List all the surgical procedures (in operating room) you have had and times you have been hospitalized for injury (last 5years):

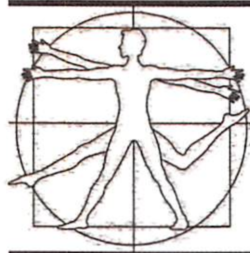
__________ __________ __________

__________ __________ __________

Patient Signature ______________________________ ***Date*** ______________

Physical Therapist's Additional Comments

____



THE BODY CENTER

PHYSICAL THERAPY AND PILATES

No Show/ Late Cancellation Policy

We require that you cancel your appointment in advance by **midnight the day before** your scheduled appointment with our ***front desk staff*** (cancelling with your aide or therapist will not count as an early cancellation). If we are unable to answer your phone call, please leave a voicemail. If this voicemail is left before midnight the day before your appointment, we will consider this an early cancellation.

When an appointment is made and not kept, it takes an available time slot away from another patient. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. Because of this, we allow ***two*** late cancellations or no-shows with no penalty. A late cancellation is cancelling the day of your appointment. A no-show is missing a scheduled appointment without notifying our front desk staff.

However, on the *third late cancellation or no show:*

1. You may pay a **$20 fee** for each late cancellation and **$30 fee** for each no-show to keep your future appointments as they are.
2. Your future appointments will be deleted and you will be required to schedule the day of for any appointments you may need.

You can avoid these penalties by calling the day before to cancel your appointment. If you do call in the day of, please reschedule your appointment for another time before Saturday of that same week. Rescheduling your appointment within these terms will act as an early cancellation.

We have tried to make this information clear and understandable. Please ask our front desk staff if you have any questions regarding our cancellation policy.

Please sign below to consent to these terms –

Patient Signature____________________________________ Date___________________

Print Name ____