

BIO MECHANIC PHYSICAL THERAPY

Medical History & Information

Last Name _____ First Name _____ M.I. _____

Street Address: _____

City _____ State _____ Zip _____

Date of Birth: _____ Social Security Number: _____

Home Phone: _____ Cell Phone/Pager _____

Work Phone: _____ Occupation: _____

Emergency Name/Contact: _____ Relationship: _____

Phone Numbers: () _____ () _____

How did you hear about us? Doctor: _____ Friend (Name): _____

Paper Ad: _____ Website: _____ Internet Search: _____ Other: _____

How would you like to receive your monthly Newsletter?

Paper/Mail _____ E-Mail (Please provide E-Mail): _____

Referring Physician: First Name: _____ Last Name: _____

Office Location: _____

Primary Care Physician: First Name: _____ Last Name: _____

Office Location: _____

Insurance Information: (Please provide cards for copying to avoid writing details)

Primary Insurance: _____ Policy Holder Name _____

Date of Birth of Policy Holder (if not self): _____

Social Security Number of Policy Holder (if not self): _____

Secondary Insurance: _____ Policy Holder? _____

Date of Birth of Policy Holder (if not self): _____

Social Security Number of Policy Holder (if not self): _____

Are you under a Home Health Plan of Care? _____ What agency? _____

Date of Discharge? _____

Date of Injury or onset: _____ Was Injury a result of an accident? _____

If yes: Job related _____ Auto _____ Other _____

Attorney (if applicable):

Name: _____

Address: _____

Phone number: _____

I hereby authorize the release of medical information necessary to process my insurance claim. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information to my attorneys, health care providers and insurance case managers. I am aware of HIPAA regulations.

I am responsible for all charges for all services provided. In the event that the insurance company denies benefits or makes a partial payment, I am responsible for any balance due. This may not apply to insurance companies that I am under contract with.

Signature: _____ Date: _____

Name _____

Medical History

For what problem are you having physical therapy?

List all medical problems:

Check any or all that apply to your present health:

- | | | |
|--|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Muscle or joint pain | <input type="checkbox"/> Tendonitis | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Numbness/tingling | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Sprains/strains |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer/tumors | <input type="checkbox"/> Sleep difficulties |
| <input type="checkbox"/> Infectious disease | <input type="checkbox"/> High cholesterol | |

List all medications/herbs/vitamins:

List physical activities you participate in regularly:

List previous major injuries/surgeries:

What other treatments are you receiving and by whom (acupuncture, physical therapy, chiropractic, naturopathic): _____

What seems to help the most? _____

What seems to aggravate the condition the most? _____

What is your main activity at work?

On phone _____ Sitting _____ Computer work _____

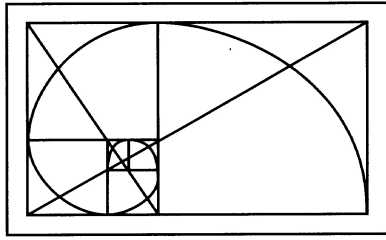
Driving car _____ Walking _____

Other _____

I will consult my practitioner with any questions or concerns immediately.

I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes.

Signature: _____ Date: _____



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Cancellation Policy

During the course of your treatment it is extremely important that you keep all of the appointments prescribed by your physician and physical therapist. This ensures that you get the best results possible.

Cancelled appointments severely impact your treatments plan as well as preventing us from scheduling patients who could have been seen that day. Not showing up also drives up the cost of patients care for everyone as staffing and overhead cost for services go unused.

We understand illness and emergencies occur. Please notify the front desk as soon as possible, this will allow us the opportunity to reschedule your appointment and make your spot available to another patient. The first cancellation will not be charged as a courtesy to you, however reoccurring cancellations with less than 24-hour notice may invoke a fee of \$40.

It is also important that you arrive on time for scheduled appointments to ensure that your therapist has enough time to spend with you and ensures the quality of care for all patients on the schedule that day.

Patient care is of the utmost importance to our staff at BioMechanic Physical Therapy; please let us know if you have any questions or concerns.

Patient Signature _____ Date: _____