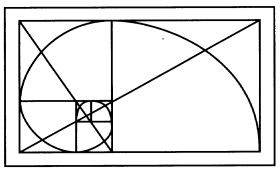

BioMechanic Physical Therapy

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:

_____Headaches	_____Chronic pain	_____Blood clots
_____Muscle or joint pain	_____ Tendonitis	_____Depression
_____Numbness/tingling	_____Fatigue	_____Arthritis
_____High/low blood pressure	_____Scoliosis	_____Sprains/strains
_____Diabetes	_____Cancer/tumors	_____Sleep difficulties
_____ Infectious disease	_____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: _____

BioMechanic Physical Therapy

Cancellation Policy

During the course of your treatment it is extremely important that you are 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:_____