Belfield physical therapy

PATIENT INFORMATION

Date _____

Patient's Name_____ ☐Male ☐Female

Address_____City_____State_____Zip _____

Home Phone_____ Work Phone_____ Cell Phone_____

Date of Birth_____ Age _____ SS#_____

Email: _____ Referring Physician_____

Would you like to receive our free monthly email newsletter? ☐Yes ☐No

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Emergency Contact_____ Relationship to Patient_____ Phone_____

How did you hear about us? ☐Previous Patient ☐Doctor ☐Insurance Plan ☐Internet
☐Phone Book ☐Friend ☐Family ☐Other:_____

INSURANCE INFORMATION

Insurance Type: ☐Health Insurance ☐Medicare ☐Work Comp ☐Auto ☐Self Pay

Primary Insurance_____ Secondary Insurance_____

Insured's Name_____ Insured DOB _____ Insured SS#_____

Have you received Home Health Services in the last 30 days? ☐Yes ☐No

Date Discharged_____ Name of Agency_____

MEDICARE PATIENTS: Have you had any physical or speech therapy already this year? ☐Yes ☐No

Is this injury accident related? ☐Yes ☐No If so, where did it occur: _____

WORKER'S COMPENSATION

Claim Number_____ Adjuster Name_____Phone_____

Employer Name_____ Employer Phone_____

Employer Address_____City_____State_____Zip_____

AUTOMOBILE ACCIDENT

Claim Number_____ Lien: ☐Yes ☐No

Adjuster Name_____ Adjuster Phone_____

Attorney's Name_____ Attorney Phone_____

Belfield Physical Therapy

TREATMENT COMMITMENT

Belfield Physical Therapy cares very much about each person we treat. We are committing to you, our patient, to deliver exceptional care, with exceptional results. We request of you, our patient, a commitment to help us deliver what we promise, by understanding what is required of you. You play a large role in your health by the actions you choose to take. Listed are some of your responsibilities as a patient at Belfield Physical Therapy:

1. **Attending, on time, all scheduled appointments.**
2. **Informing your therapist of your progress, each visit.**
3. **Compliance with your treatment plan developed by your therapist.**
4. **Asking questions when you do not understand any instructions given to you by our staff.**
5. **Notifying your therapist in advance of your next doctor's appointment.**

PATIENT MISSED APPOINTMENT POLICY

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well-being and gain of your abilities is something every one in our clinic takes quite seriously. Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore we have certain rules that need to be followed in order to ensure the most optimum results. **Belfield Physical Therapy reserves the right to charge $30 for any cancellations not made 24 hours in advance and a no show charge of $50. After the second no show or third cancelled appointment all future appointments will be removed from the schedule and you will be added to our "same day appointment only" list.**

INSURANCE

Belfield Physical Therapy makes every effort to verify coverage with your insurance company. However, it is important for you to refer to your insurance policy to verify details, including limitations, regarding your coverage for outpatient physical therapy. We file insurance as a courtesy; however, our relationship is with you, not the insurance company.

The patient (or parent, if the patient is a minor) is responsible for payment of charges incurred at Belfield Physical Therapy. If payment is not received from the insurance company, workers compensation or another source within a reasonable period of time, the patient (or parent, if the patient is a minor) will be billed. Patients are responsible for paying co-pays, co-insurance, deductibles, non-covered supplies and services, which exceed benefit limitations according to the terms of their insurance policy/policies. If you are a Private Pay client or prefer to send claims to your insurance company yourself, payments are due at the time you receive services. Medicare patients are not responsible for claims denied by Medicare.

If you have more than one insurance policy, we can only bill one insurance company at a time. After your primary carrier responds to your claim, we will bill your secondary for the remainder. If your injury resulted from an automobile accident, your auto insurance carrier will be billed first.

PRIVACY NOTICE

Belfield Physical Therapy maintains the privacy of patient health information. I am aware that a Notice of Privacy Policies is posted in the waiting room and that I may ask that secretary for a copy of the notice to take home with me.

I authorize the release of any medical information necessary to process the claim for services rendered to me. I further authorize payment of medical benefits directly to the therapist/clinic.

I hereby acknowledge that I consent to treatment at Belfield Physical Therapy and all information I've given is accurate.

X_____ _____

Patient or authorized person (signature) **Date**

Therapist Use Only Patient Category: 1 2 3 _____x a week for _____weeks

Belfield physical therapy

Date: _____

PERSONAL INFO: Name_____Height_____Weight_____

EMPLOYMENT: Employer Name_____ Occupation/Job Title: _____

If not working, number of days/weeks/months/years you have been off work: _____

Are you currently under any restrictions from your doctor? ☐ Yes ☐ No

If so, why? _____

CURRENT HISTORY:

What is your main problem or issue? _____

When did it start? _____ Date of Surgery: _____Date of next doctor visit: _____

How did it start? ☐Accident ☐Overuse ☐Sports Injury ☐Surgery ☐Work ☐Unknown

☐Other: _____

Rate the current level of your pain:

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst imaginable pain)

Is your pain: ☐Constant ☐Intermittent ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Tingling

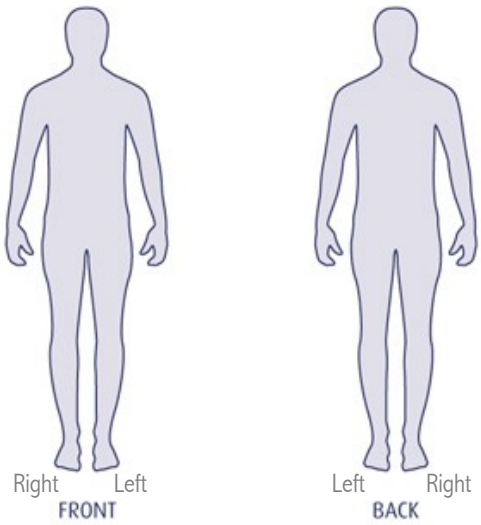
☐Worse in AM ☐Worse in PM

On the diagram to the right;

Please indicate where you have pain:

Circle - areas of pain/soreness

XX - areas of numbness/tingling



What makes your symptoms better?_____

_____

What makes your symptoms worse?_____

_____

Current Activity level: 0% = bedridden 100% = able to perform all pre-injury activities

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

CONTINUED→

MEDICAL HISTORY

Circle any of the conditions below that you have experienced:

Musculoskeletal	**Nervous**	**Circulatory**
Carpal tunnel syndrome	Headaches	Aneurysm
Fibromyalgia	Multiple Sclerosis	Clotting Disorder
Osteoarthritis	Numbness/Tingling	Diabetes Type1/Type 2
Rheumatoid Arthritis	Parkinson's Disease	Heart Attack
Sciatica	Peripheral Neuropathy	Heart Disease
Spinal Dysfunction	Post Polio Syndrome	High Blood Pressure
Sprains/Strains	Seizures	Pace Maker
Tendonitis	Shingles	Peripheral Artery Disease
Thoracic Outlet Syndrome	Stroke	Varicose Veins
TMJ Dysfunction		
Lymph and Immune	**Integumentry**	**Miscellaneous**
AIDS, HIV	Boils	Allergies
Chronic Fatigue Syndrome	Eczema	Cancer (Other than above)
Edema	Fungal Infection	Changes in Bowel Habits
Hodgkins' Disease	Skin Cancer	Changes in Bladder Habits
Lymphoma	Warts	Dizziness/Fainting
Lupus	**Digestive**	Fever/Chills/Night Sweats
Respiratory	Diverticulitis	Mental Disorder
Asthma	Gallstones	Metal Implants
COPD	Heartburn	Serious Personal Injuries
Emphysema	Hepatitis	Severe Night Pain
Tuberculosis	Irritable Bowel Syndrome	Unexplained Weight Loss
	Ulcerative Colitis	

List any significant operations and past medical history: _____

_____

How is your general health? ☐Poor ☐Fair ☐Good ☐Excellent

List any specific known drug and/or allergic reactions: _____

_____

List current medications (or bring copy): _____

_____

Is there any chance you may be pregnant at this time? ☐Yes ☐No

Since the onset of this problem, have you had any of the following interventions?

☐Surgery ☐MRI ☐CT Scan ☐X-Rays ☐Injections ☐Nerve Blocks

☐Bone Scan ☐Blood Tests ☐Massage ☐Chiropractic ☐Physical Therapy

☐Acupuncture ☐Other: _____

Patient Goals: List 3 important activities you wish to improve or return to with the help of therapy:

1: _____

2: _____

3: _____