

# BETHESDA

## PHYSICAL THERAPY

Today's date: \_\_\_\_\_

### PATIENT INFORMATION

Patient name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Address: \_\_\_\_\_

Phone (H): \_\_\_\_\_ (W): \_\_\_\_\_ (C): \_\_\_\_\_

Sex:  M  F Patient's date of birth: \_\_\_\_\_

Marital status:  Married  Single  Divorced  Widowed

Employed?  Yes  No Employer/School: \_\_\_\_\_

Referring physician: \_\_\_\_\_

### PERSON RESPONSIBLE FOR PAYMENT

Guarantor name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Address: \_\_\_\_\_

Phone (H): \_\_\_\_\_ (W): \_\_\_\_\_ (C): \_\_\_\_\_

Sex:  M  F Guarantor's date of birth: \_\_\_\_\_

Marital status:  Married  Single  Divorced  Widowed

### INSURANCE INFORMATION

Primary insurance company: \_\_\_\_\_ Insured's name: \_\_\_\_\_

Insured's date of birth: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Insured's employer: \_\_\_\_\_

### ADDITIONAL INFORMATION (Complete only for Worker's compensation or an auto accident.)

Worker's compensation  Third party liability  Auto accident

Insurance company: \_\_\_\_\_ Claim number: \_\_\_\_\_

Insurance company address: \_\_\_\_\_

If worker's compensation, name and address of employer at time of injury: \_\_\_\_\_

Contact name: \_\_\_\_\_ Contact phone: \_\_\_\_\_

I, \_\_\_\_\_, understand that upon the exhaustion of my PIP/Worker's Compensation benefits, Bethesda Physical Therapy, as a courtesy to me, will bill my primary health insurance. I will, however, be responsible for any documentation necessary for the billing process and for ALL charges not covered thereof.

SIGNATURE: <sup>x</sup> \_\_\_\_\_

DATE: \_\_\_\_\_

**Registration continued on next page...**

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## PHYSICAL THERAPY

### EMERGENCY CONTACT

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_

Phone (H): \_\_\_\_\_ (W): \_\_\_\_\_ (C): \_\_\_\_\_

### INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Bethesda Physical Therapy to furnish information to the insurance carriers listed above concerning my illness and treatments.

SIGNATURE: x \_\_\_\_\_

DATE: \_\_\_\_\_

I hereby assign to Bethesda Physical Therapy all payments for medical services rendered to myself or my dependents until revoked in writing. I understand that I am responsible for any amount not covered by insurance at the time of service. I also understand that I am responsible for collection and legal costs should it be necessary for this account to be turned over to a collection agency.

SIGNATURE: x \_\_\_\_\_

DATE: \_\_\_\_\_

### USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The "Notice of Privacy Practices" states the manner in which Bethesda Physical Therapy may use or disclose health information for the purposes of treatment, payment for treatment or health care operations in compliance with HIPPA Regulations.

I hereby acknowledge knowledge of the "Notice of Privacy Practices" and consent to the use and disclosure of my personal health information as outlined. I understand that I reserve the right to revoke this consent, in writing, except when disclosures have been made with my prior consent.

\_\_\_\_\_  
Name of Patient or Guardian (*Please print*)

x \_\_\_\_\_

Signature of Patient or Guardian

Date

### CANCELLATION POLICY

I hereby acknowledge that I may be charged a fee of \$25 if I do not give 24-hour notice for cancellation of appointments.

x \_\_\_\_\_

Signature of Patient or Guardian

Date

# BETHESDA

PHYSICAL THERAPY

## PATIENT INFORMATION FORM

Today's date: \_\_\_\_\_

Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Age: \_\_\_\_\_

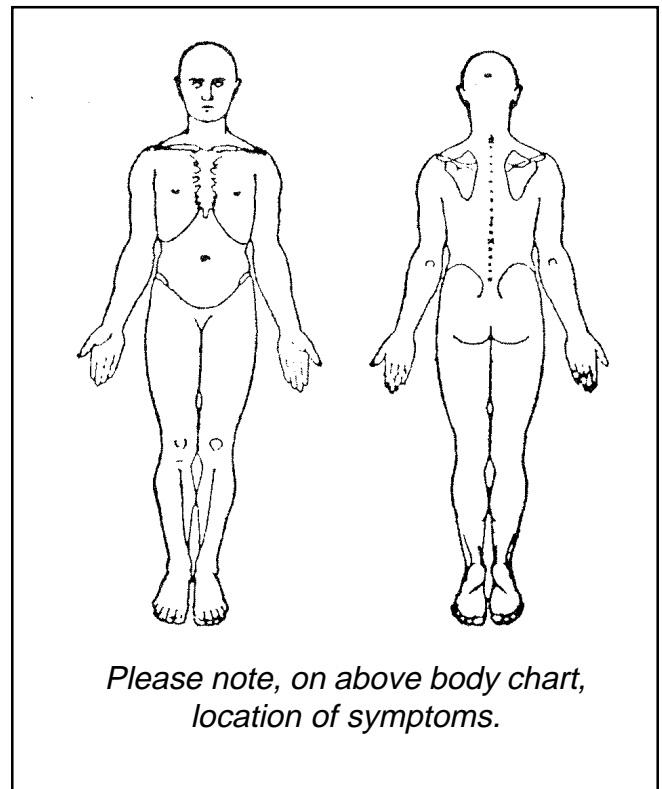
Physician: \_\_\_\_\_

Date of Onset: Injury/Program/Surgery: \_\_\_\_\_

Briefly state previous treatment, if any: \_\_\_\_\_

*Do you have now, or have you ever had, any of the following?*

DIABETES	YES	NO
ALLERGY TO COLD	YES	NO
HIGH BLOOD PRESSURE	YES	NO
OTHER ALLERGIES	YES	NO
PACEMAKER	YES	NO
PREVIOUS SURGERY	YES	NO
CHRONIC HEADACHES	YES	NO
SEIZURES	YES	NO
KIDNEY PROBLEMS	YES	NO
METAL IMPLANTS	YES	NO
NERVOUS DISORDERS	YES	NO
DIZZINESS	YES	NO
HERNIA	YES	NO
CANCER	YES	NO
ALLERGY TO HEAT	YES	NO
PREGNANT	YES	NO
BONE DISEASE	YES	NO
OSTEOPOROSIS	YES	NO
FRACTURES	YES	NO
BOWEL PROBLEMS	YES	NO
BLADDER PROBLEMS	YES	NO
RECENT WEIGHT LOSS	YES	NO
PINS & NEEDLES	YES	NO
CIRCULATORY DISEASE	YES	NO
PROBLEMS WITH BOTH ARMS OR BOTH LEGS AT THE SAME TIME	YES	NO



If YES to any of the above, please explain and give appropriate details: (use back of sheet, if necessary):

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**PATIENT COPY**  
*(Please retain for your records.)*

# **BETHESDA**

**PHYSICAL THERAPY**

## **NOTICE OF PRIVACY PRACTICES**

### **PATIENT'S INDIVIDUAL RIGHTS**

You have the right to obtain a copy of your health record at any time. You may revoke your authorization to use or disclose health information except when disclosures have been made with your prior consent.

### **BETHESDA PHYSICAL THERAPY RESPONSIBILITIES**

It is this organization's legal duty to maintain the privacy of your health information, provide this notice and notify you of any revisions made.

### **USE AND DISCLOSURE OF HEALTH INFORMATION**

- Bethesda Physical Therapy may use your health information for treatment, obtaining payment for treatment, conducting internal administrative functions and evaluating the quality of care.
- Bethesda Physical Therapy may use or disclose health information without prior authorization for public health purposes, auditing purposes and for emergencies. We also provide information when required by law.
- Bethesda Physical Therapy may share your health information in communication with members of your family involved in your care.
- Bethesda Physical Therapy may contact you to provide information and services that may be of interest to you.

# BETHESDA

## PHYSICAL THERAPY

### PATIENT PAIN/FUNCTION QUESTIONNAIRE

Patient Name: \_\_\_\_\_

1. Chief complaint (*Please describe.*) \_\_\_\_\_

Date of onset of this episode \_\_\_\_\_

Are you currently employed?  yes  no Occupation \_\_\_\_\_

Are you currently not working or working less than full time (or full duty) due to these symptoms?

yes  no

What activities/duties at work are you unable to perform or have difficulty with secondary to pain?

2. Rate your pain intensity on the 0 to 10 scale (10 being the worst pain imaginable)

Average pain intensity over past week:

Working at your computer/desk \_\_\_\_\_

Dressing \_\_\_\_\_

Washing/brushing hair \_\_\_\_\_

Reaching above shoulder level \_\_\_\_\_

Turning your head and neck \_\_\_\_\_

Climbing stairs \_\_\_\_\_

Getting in/out of car \_\_\_\_\_

Turning over in bed \_\_\_\_\_

Walking two blocks \_\_\_\_\_

Reaching behind your back \_\_\_\_\_

3. Average number of times you wake up each night due to your pain \_\_\_\_\_

4. Sitting tolerance \_\_\_\_\_ minutes

5. Driving tolerance \_\_\_\_\_ minutes

6. Standing tolerance \_\_\_\_\_ minutes

7. Walking tolerance \_\_\_\_\_ minutes

8. Limitations with yard work/home projects?  yes  no

Briefly describe activities: \_\_\_\_\_

Limitations with recreation/leisure sports?  yes  no

Briefly describe activities: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_