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: x ______________

DATE: ______________

Registration continued on next page...

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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

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PATIENT INFORMATION FORM

Today's date: ____________________

Name: ____ Occupation: __________________________________
Age: __________

Physician: ____

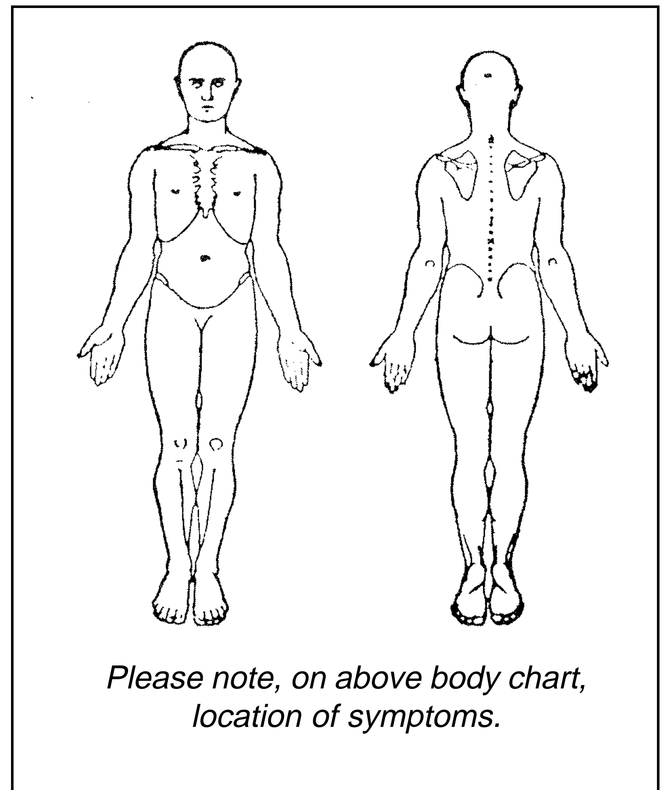
Date of Onset: Injury/Program/Surgery: ____

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 ____



Please note, on above body chart, location of symptoms.

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

____

____

____

____

PATIENT COPY
(Please retain for your records.)

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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.