BETHESDA
PHYSICAL THERAPY

Today's Date: _____

PATIENT INFORMATION

Patient name: (Last) _____ (First) _____ (M) _____

Address: _____

Phone (H) _____ (W) _____ (C) _____

Sex: ☐ M ☐ F Patient's Date of Birth: _____

Email: _____

Employed? ☐ Yes ☐ No Employer/School: _____

Referred by: _____ Physician: _____

PERSON RESPONSIBLE FOR PAYMENT

Guarantor name: (Last) _____ (First) _____ (M) _____

Address: _____

Phone (H): _____ (W): _____ (C): _____

Sex: ☐ M ☐ F Guarantor's Date of Birth: _____

INSURANCE INFORMATION

Primary Insurance Company: _____ Insured's Name: _____

Insurance Policy ID#: _____Insured's Date of Birth: _____

Relationship to Patient: _____ Insured's Employer: _____

Secondary Insurance Company: _____Insurance Policy ID: _____

EMERGENCY CONTACT

Name: (Last) _____ (First) _____ (M) _____

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 Date

I hereby assign to Bethesda Physical Therapy all payments for medical services rendered to myself or my dependants 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 Date

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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 prior to my consent.

_____
Name of Patient or Guardian (Please print)

_____ _____
Signature Date

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

Date of Accident: _____

☐ Worker's Compensation ☐ Third Party Liability ☐ Auto Accident

Insurance Company: _____ Claim #: _____

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 for ALL charges not covered thereof.

_____ _____
Signature Date

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PHYSICAL THERAPY

Name: _____ **Age**: _____ **Height**: _____ **Weight**: _____

Referred by: _____ **Physician**: _____

Chief Complaint (Please Describe): _____

_____

Date of Onset of this Episode: _____ Are You Currently Employed? Yes ☐ No ☐

Occupation: _____

List one important activity you are unable to do or have difficulty performing as a result of your Pain/Symptoms:

_____

Have you RECENTLY noted any of the following (check all that apply)?

☐ changes in bowel or bladder function	☐ weight loss/gain	☐ fever/chills/sweats
☐ nausea/vomiting	☐shortness of breath	☐ pain at night
☐ dizziness/lightheadedness	☐ headaches	☐ weakness/fatigue
☐ difficulty maintaining balance while walking	☐ changes in appetite	☐ difficulty swallowing

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

☐ cancer (type)_____	☐ rheumatoid arthritis	☐ diabetes
☐ heart disease	☐ stroke	☐ multiple sclerosis
☐ high blood pressure	☐ depression	☐ kidney/liver problems
☐ asthma	☐ anemia	☐ stomach ulcers
☐ pacemaker inserted	☐ lung problems	☐ epilepsy
☐ osteoporosis	☐ thyroid problems	☐ Parkinson's disease
☐ chemical dependency (i.e., alcoholism)	☐ other_____	☐ other_____

Have you fallen recently? **YES** **NO** How many times have you fallen in the last year? _____

Pain at LOWEST: Rate your lowest pain level in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10

No pain — Worst Pain Imaginable

Pain Currently: Rate your level of pain at this time.

0 1 2 3 4 5 6 7 8 9 10

No pain — Worst Pain Imaginable

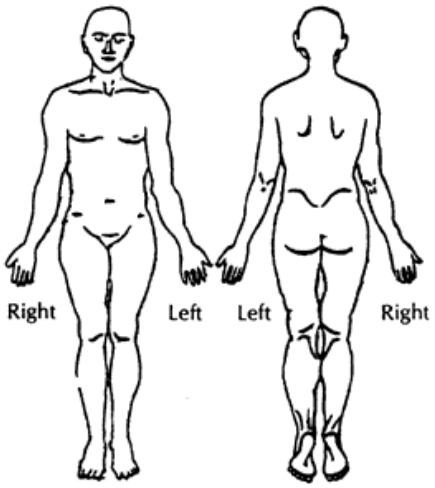
Pain at WORST: Rate your highest pain level in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10

No pain — Worst Pain Imaginable

Body Chart

Please mark the location of your pain on the chart:



What is your goal for therapy at this time? _____

Patient Signature: _____ **Date**: _____

BETHESDA
PHYSICAL THERAPY

NOTICE OF PRIVACY PRACTICES

BETHESDA PHYSICAL THERAPY PLEDGE

It is our legal duty to maintain the privacy and security of your protected health information, and ensure that it is used and disclosed only as described by this Notice

USE AND DISCLOSURE OF MEDICAL INFORMATION

- For Treatment - Our clinical staff will use your medical information in providing you medical treatment.
- For Teaching Purposes - We mentor students interested in the field of Physical Therapy. However, you have the right to refuse sharing your personal health information with these individuals.
- For Verification of Benefits and Claim Payments – We will provide your insurance company information about you to receive benefit information and claim payments. Patients may restrict disclosures to a health plan if they pay for services out of pocket and in full.
- For Certification of care – We will communicate with your doctor regarding your care
- For internal administrative functions and evaluating quality of care. All members of our staff are HIPAA compliant.
- We may use or disclose your health information without prior authorization for public health purposes, aiding purposes and for emergencies. We may also release personal information to the appropriate government agency if abuse, neglect or violence is suspected.
- For lawsuits – We will provide medical information in response to a subpoena, a discovery request or summons.
- We may share your health information with members of your family or others involved in your care. Family members are allowed access to the health information of a decedent patient
- Our business associates are in compliance with all aspects of the privacy and security of medical information. We maintain strict agreements for the privacy and security of patient health information.
- We may contact you to provide information regarding services that may be of interest to you, but your information will not be shared with, or sold to, any other organization for marketing or fundraising.

PATIENTS' INDIVIDUAL RIGHTS

Other than for purposes listed above, we will only disclose your personal health information with written authorization from you. You have the right to revoke your authorization except when disclosures had been made prior to consent.

You have the right to obtain a copy of your health record, by paper or electronically.