BODY AWARENESS PHYSICAL THERAPY, INC

CHART #_______________ (For Office Use)

PATIENT INFORMATION

Name_______________________________________ SS#__________________________ M or F
Address_______________________________ City___________________ St_____ Zip_________
Home Phone(____)_______________ Wk. Phone(____)_____________ Cell (____)_______________
Birth date____/____/____ Age_____ Marital Status: M S W D Other (circle one)
Occupation________________________ Employer_______________________________________
Employer's Address___________________________ City___________________ Zip___________
Spouse's Name_____________________ Employer_______________________________________
Referring Physician____________________________________
**Please circle the phone number(s) you would prefer our office used to contact you or leave voicemail regarding appointments or medical information.*

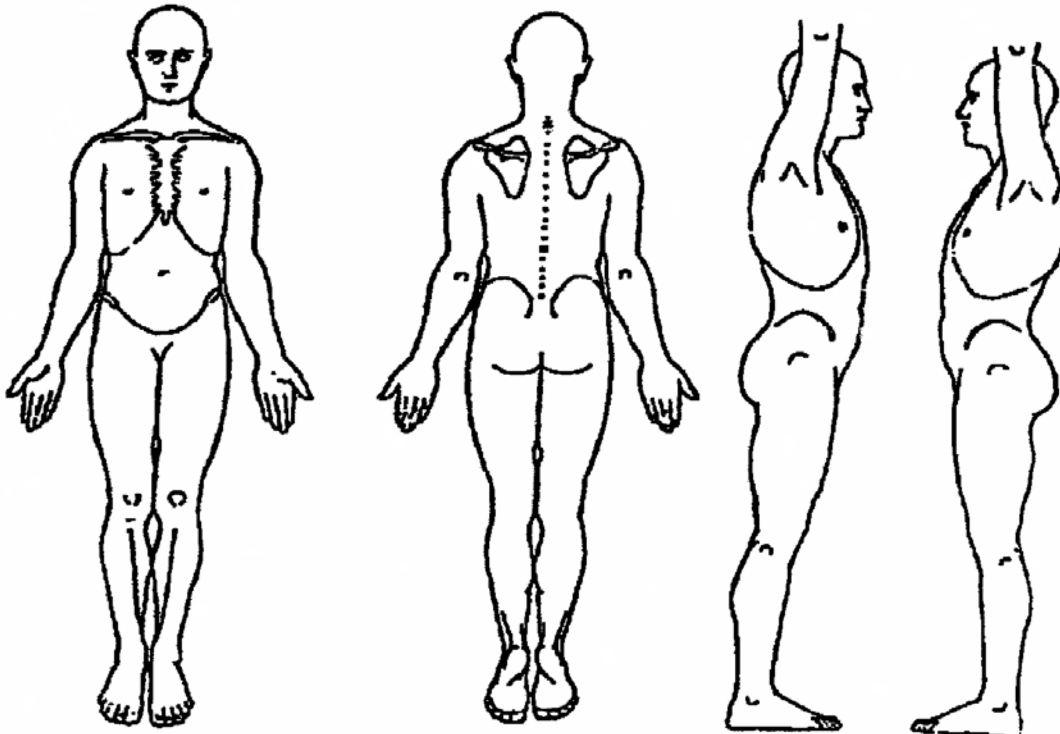
Is your injury due to a motor vehicle accident? Yes No Were you injured at work? Yes No If yes, when?_____________________________ ____________ Initial/Date

Emergency Contact Name: __________________________________ Relation:_________________
Day Phone(____)_____________ Evening Phone(____)_____________ Cell (____) _______________

How did you hear about us? ____
Email Address: ____

Body Diagram

Directions: On the body diagram below, please mark the areas of your symptoms as they are at this moment.



______initials

MEDICAL HISTORY

Please indicate (X) any of the following whose care you are under:

____Medical Doctor ____Psychiatrist/Psychologist Other____________________
____Osteopathic Physician ____Physical Therapist
____Dentist ____Chiropractor

If you have seen any of the above for care during the past three months then please describe for what reasons (illness, medical condition, physical exam, etc.):____

Please indicate (X) whether you have ever been diagnosed with:

____Heart Disease of Heart Attack
____High Blood Pressure
____Circulation problems
____Anemia or Blood Disorders
____Bleeding Disorders
____Chemical Dependency
____Tumor or Cancer
____Kidney or Bladder Problems
____Stroke/TIA
____Epilepsy/ Seizures
____Diabetes
____Fibromyalgia/myofascial pain syndrome
____Osteoporosis
____Respiratory Disease
____Asthma
____Thyroid problems
____Hernia
____Depression

Other condition: ____
If you have checked any of the conditions, please explain____
____

Have any of your immediate family members been treated for any of the above conditions? If so, then please state what conditions and your relation.____

Are you pregnant now? Yes No

Have you had any illnesses in the last three weeks (e.g. colds, influenza, other infections)? YES NO
Describe:____

Please list all previous surgical procedures or hospitalizations, with approximate dates and reasons.
____
____

Do you have any surgical implants (plastic, metal…)? Yes No Explain_________________________

Please list all medications you are currently taking:____
____

Please list all allergies:____

Please list all imaging, with approximate dates (X-Ray, MRI, CT scan, Bone scan, PET scan, Ultrasound, EMG/Nerve conduction tests, etc.)

Date	Image/Body Region	Date	Image/Body Region
____	________________________________	____	________________________________
____	________________________________	____	________________________________
____	________________________________	____	________________________________

How many packs of cigarettes do you smoke per day?_______
Do you drink alcohol?___ How many days per week?___ How much do you drink per average sitting?______
Do you exercise regularly? YES NO What type of exercise and how often?_______________

CONSENT TO TREAT

My signature below is my consent to receive and pay for physical therapy treatment at Body Awareness Physical Therapy, Inc.

Patient Signature:____ Date:______________________
Parent/ Guardian Signature(if minor): _____________________________Date:______________________

BODY AWARENESS PHYSICAL THERAPY, INC

ASSIGNMENT OF BENEFITS

I hereby instruct my health, auto, or accident insurance carrier to pay directly to Body Awareness Physical Therapy, Inc. any benefits payable to me under my insurance policy. If my policy prohibits direct payment to my provider, then I instruct my insurance carrier to make a check payable to me, but mailed directly to the provider named above. This is a direct assignment of my rights and benefits under my policy. I also give Body Awareness Physical Therapy, Inc. the right to act as my agent under a power of attorney to endorse checks made out to me, to be credited to my account. A copy of this assignment shall be considered as effective and valid as the original. I also authorize Body Awareness Physical Therapy, Inc. to release any information pertinent to my case to any insurance company, adjustor, attorney or other persons entitled to said information who requests such information in writing.

I clearly understand and agree that all services rendered to me are charged to me and that I am personally responsible for payment, regardless of any insurance, because health, auto, or accident insurance policies are an arrangement between the insurance carrier and me.

I am responsible for payment of overdue balances, which will be subject to a $35.00 late payment fee on balances 30 days over due. I am also responsible to pay a $25.00 fee applied to any returned checks. All additional fees are payable directly to Body Awareness Physical Therapy, Inc.

___________________________	___________________________	____________________
Print Name	Signature	Date
___________________________	___________________________	____________________
Responsible Party if Not Patient	Signature	Date

BODY AWARENESS PHYSICAL THERAPY, INC

NOTICE OF PRIVACY PRACTICES

Effective: April 14, 2003

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully:

Understanding your health record/information:
When receiving physical therapy services from Body Awareness Physical Therapy, Inc., a record is made of your treatment. This record contains your symptoms, diagnoses, examinations, assessments, evaluation and your treatment plan. It also contains daily treatment notes and progress notes. This record is referred to as your medical record and serves as a:

- Basis for planning your care and treatment
- Means of communication among the health professionals who contribute to your care
- Legal document describing the care you receive
- Means by which services can be verified for billing purposes
- A tool for educating physical therapy professionals
- A source of data for facility planning
- A tool with which the quality and outcome of care and services given can be evaluated.

Our pledge regarding medical information:
We understand the medical information about you is personal. We are committed to protecting this information. We create a record of care and services you receive. This record is needed to provide you with quality care and to comply with certain legal requirements. This notice applies to the records for your treatment.

How we may use and disclose your medical information:

1. **For treatment:** We may use medical information about you to provide you with treatment. We may disclose this information to your doctors, or other personnel who are involved in your treatment.
2. **For payment**: We may disclose medical information about you so that the treatment you receive may be billed to and payment may be collected from insurance or other benefits that you may be entitled to.
3. **Review for quality care**: we may disclose medical information about you for internal quality check to make sure all of our patients receive quality care.
4. **As required by Law:** We will disclose medical information about you when required to do so by federal, state or local law.
5. **Lawsuits and Disputes**: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

I have read and understand the information outlined above.

____________________	____________________	____________________
Print Name	Signature	Date
____________________	____________________	____________________
Responsible Party if Not Patient	Signature	Date

BODY AWARENESS PHYSICAL THERAPY, INC

CANCELLATION/ NO SHOW POLICY

In order to maintain the high level of quality care and one- on-one service provided at Body Awareness Physical Therapy we ask that our patients comply with a **24-hour** cancellation policy. Body Awareness requires a 24-hour advance notification when canceling an appointment. If the patient fails to comply with this 24-hour cancellation policy a fee of $75.00 for 30 minute scheduled appointment/ $150.00 for 60 minute scheduled appointment will be charged to the patient's account due the following scheduled visit. Body Awareness reserves the right to bill the patient for any uncollected cancellation fees.

____
Initial & Date

OVER DUE BALANCES AND FEES

I understand I will be responsible for payment of overdue balances, which will be subject to a $35.00 late payment fee on balances 30 days over due. I am also responsible to pay a $25.00 fee applied to any returned checks. All additional fees are payable directly to Body Awareness Physical Therapy, Inc.

____
Initial & Date

By signing this form I agree to the terms of the CANCELLATION POLICY and OVER DUE BALANCES AND FEES POLICY as stated above.

Print Name	Signature	Date
Responsible Party if Not Patient	Signature	Date