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

BETHESDA

PHYSICAL THERAPY

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

CANCELLATION POLICY

I hereby acknowledge that I may be charged a fee of $30 if I do not give 24-hour notice for cancellation of appointments.

_____

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

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 pain?

_____

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

Average pain intensity over past week:	_____
Working at you computer/desk	_____
Dressing	_____
Washing/brushing hair	_____
Reaching above your 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 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:** _____

BETHESDA

PHYSICAL THERAPY

PATIENT INFORMATION FORM

Today's Date: _____

Name: _____ Occupation:

_____

Age: _____ Height: _____ Weight: _____

Physician: _____

Date of Onset: Injury/Program/Surgery: _____

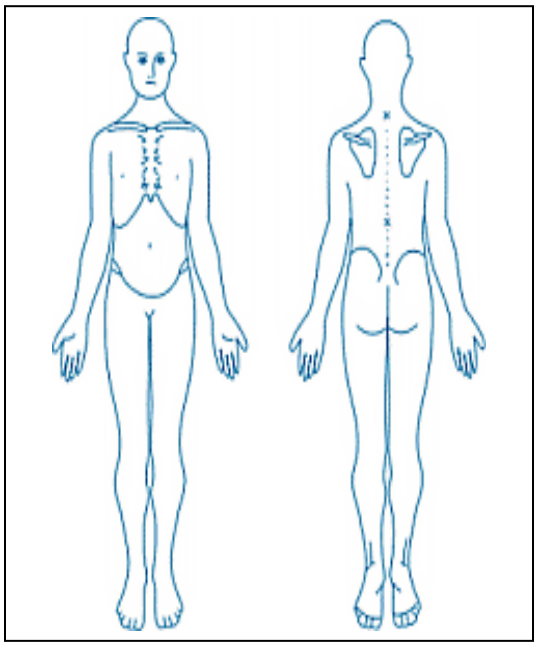
Briefly state previous treatment, if any:

_____

_____

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 DISORDER	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 your symptoms

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

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.

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PHYSICAL THERAPY

Measure 130: Current Medications in the Medical Record

Name of Patient: _____

Date: _____

List of Current Medications:

(Include prescription, over-the-counter, herbals, vitamin/mineral/dietary supplements)

Drug name	Dosage	Frequency	Medical Condition

Medicare Physician Quality Reporting System(PQRS)

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