Physical Therapy Health History Form

Name: _____

Referring MD: _____

Date of Birth: _____

Do you now, or have you in the past, had any of the following? Fill in YES/NO

1. Heart problems, chest pain, or a pacemaker? ___
2. Stroke? ___
3. High/low blood pressure? ___
4. History of fainting or passing out? ___
5. Diabetes? ___
6. Arthritis or joint pain? ___
7. Any chronic illness or condition? ___
8. Recent (in the last 12 months) or major surgery? ___
9. Pregnancy? ___
10. Headaches or migraines? ___
11. Osteoporosis? ___
12. Glaucoma? ___
13. Any condition that may be aggravated by working out? ___
14. Instruction from physician preventing or limiting activity? ___

Please explain any YES answers:

Please list any current medications:

List all current recreational activities and/or sports:

List your specific fitness and health goals (if any):

Have you had any Diagnostic Imaging (X-Ray, MRI, CT Scan, etc.) that would assist us in your treatment?

If yes, please provide date, location, and ordering MD:

We believe in a holistic approach to health and fitness. Each individual is unique, and we will work with you and your goals to create a program to educate, empower, and encourage you!

I, the undersigned, state that everything on this form is true to the best of my knowledge:

Signature:_____ Date: _____

BERKELEY COMMUNITY PHYSICAL THERAPY, INC.

DATE_____ REFERRING PHYSICIAN_____

PATIENT INFORMATION

Last Name_____First_____M.I,____

Are you known by any other name? ☐ Yes, Name_____ ☐ No

Address_____ City_____ State ____ Zip_____

Home Phone_____ Cell_____ Work_____

Date of Birth_____ Sex ☐M ☐F Driver's Lic. #_____

Marital Status: ☐M ☐S ☐D ☐W ☐DP Spouse/DP Name_____

In case of emergency, notify:_____ Relation_____Phone #_____

Is this a work related injury? ☐ Yes ☐No Date of Injury_____

Is this an accident related injury? ☐ Yes ☐ No Date of Injury_____

If an attorney is involved, name of attorney_____

PRIMARY INSURANCE INFORMATION

Primary Insured Name_____ DOB of Insured_____

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child

Group #_____ Certificate # or ID # (incl 3 letter prefix) _____

Insurance Company Name _____

Billing Address _____

City_____ State_____ Zip_____ Phone_____

BERKELEY COMMUNITY PHYSICAL THERAPY, INC.

PATIENT INFORMATION CONSENT FORM

I have read and fully understand Berkeley Community Physical Therapy, Inc.'s "Notice of Patient Information Practices". I understand that Berkeley Community Physical Therapy, Inc. may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Berkeley Community Physical Therapy, Inc. will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Berkeley Community Physical Therapy, Inc.'s "Notice of Patient Information Practices." I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____ _____

Signature Date

_____

Patient Name (print)

ASSIGNMENT OF BENEFITS

Authorization of pay Berkeley Community Physical Therapy, Inc.

I hereby authorize my insurance benefits to be paid directly to Berkeley Community Physical Therapy, Inc. and I am financially responsible for copays, coinsurance amounts, and non-covered services. I also authorize Berkeley Community Physical Therapy, Inc. to release any information requested to process this claim.

**Payments are due within 30 days. Late payments are subject to 1.5% finance charge per month.

_____ _____

Signature Date

FINANCIAL POLICY

As a courtesy, we call your insurance company to verify physical therapy benefits. Below is a summary of the information given. **PLEASE NOTE THAT THIS IS NOT A GUARANTEE OF PAYMENT.** We encourage you to also call your insurance company to verify your physical therapy benefits.

☐ Copay: _____

☐ Coinsurance: _____% per visit
Your coinsurance amount will be collected at the time of your visit.

☐ Deductible: _____Deductible Met: _____Balance: _____

You remain responsible for payment in full to Berkeley Physical Therapy, Inc. If your insurance company denies or delays payment for more than 30 days from the date your claim was billed.

24 HOUR CANCELLATION POLICY: A $140 new evaluation or $70 follow up appointment no show/late cancel fee will be billed directly to you. Two consecutive no shows may result in the removal of future appointments from the schedule.

WORKERS COMP PATIENTS: You are not required to pay for your physical therapy visits if you have authorization from your workers compensations insurance company. If your workers comp carried will not authorize treatments, you have the option of paying for each visit or having us bill your health insurance.

AUTO ACCIDENT PATIENTS: If your auto insurance covers medical payments and you can provide us with the pertinent information to verify coverage, we will bill your auto insurance company for you. We do not accept liens.

PRIVATE/SELF PAY PATIENTS: You are required to pay in full for each visit.

I have read and agree to the terms stated above. I understand that I am ultimately responsible for any amount not covered by my insurance company.

_____
Signature

_____
Date

_____
Print Name