

ASSIGNED TO: _____ OT ____ PT ____ SLP _____ APPT. DATE _____

PATIENT INFORMATION

LAST NAME	FIRST	MI	DATE OF BIRTH	SOCIAL SECURITY NUMBER	SEX
HOME ADDRESS		CITY	STATE	ZIP CODE	HOME PHONE ()
MARITAL STATUS SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> OTHER <input type="checkbox"/>			HAVE YOU BEEN TREATED AT THIS OR ANY OTHER PHYSICAL THERAPY CLINIC BEFORE? IF YES WHEN?		
EMPLOYMENT STATUS EMPLOYED <input type="checkbox"/> FULL TIME STUDENT <input type="checkbox"/> N/A <input type="checkbox"/>		EMPLOYER NAME/SCHOOL NAME		TITLE/POSITION	
WORK ADDRESS		CITY	STATE	ZIP	WORK PHONE ()
E-MAIL ADDRESS:					

REFERRING PHYSICIAN INFORMATION

LAST NAME	FIRST	MI	ADDRESS	TELEPHONE ()
-----------	-------	----	---------	------------------

EMERGENCY CONTACT OR LEGAL GUARDIAN INFORMATION

LAST NAME, FIRST NAME	RELATIONSHIP TO PATIENT	TELEPHONE ()
-----------------------	-------------------------	------------------

RESPONSIBLE PARTY STATEMENT

AS THE RESPONSIBLE PARTY, I AGREE THAT ALL CHARGES THAT ARE NOT DIRECTLY PAID BY MY INSURANCE COMPANY WILL BE MY RESPONSIBILITY.	
RESPONSIBLE PARTY SIGNATURE:	DATE:

PRIMARY INSURANCE COMPANY INFORMATION

PRIMARY INSURANCE COMPANY NAME		ID NUMBER	GROUP NUMBER	
ADDRESS	CITY	STATE	ZIP CODE	PHONE
POLICY HOLDER (IF OTHER THAN PATIENT)		SEX	DATE OF BIRTH	
SOCIAL SECURITY NUMBER (POLICY HOLDER)		PHONE NUMBER (OF POLICY HOLDER)		RELATIONSHIP TO PATIENT
POLICY HOLDER EMPLOYER NAME AND ADDRESS			PHONE NUMBER	

SECONDARY INSURANCE COMPANY INFORMATION

PRIMARY INSURANCE COMPANY NAME		ID NUMBER	GROUP NUMBER	
ADDRESS	CITY	STATE	ZIP CODE	PHONE
POLICY HOLDER (IF OTHER THAN PATIENT)		SEX	DATE OF BIRTH	
SOCIAL SECURITY NUMBER (POLICY HOLDER)		PHONE NUMBER (OF POLICY HOLDER)		RELATIONSHIP TO PATIENT

ASSIGNMENT OF BENEFITS/AUTHORIZATION OF RELEASE MEDICAL INFORMATION/CONSENT TO TREATMENT

I HEREBY ASSIGN ALL MEDICAL BENEFITS TO WHICH I AM ENTITLED TO THE BIOMECHANICS PHYSICAL THERAPY & SPORTS MEDICINE IN THE EVENT THEY FILE INSURANCE ON MY BEHALF. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. IN THE EVENT MY ACCOUNT BECOMES DELINQUENT AND IS THEREFORE IN DEFAULT OF PAYMENT, I ACCEPT RESPONSIBILITY FOR THE PRINCIPAL AMOUNT OWING AS WELL AS ALL REASONABLE COSTS ASSOCIATED WITH THE COLLECTION OF THIS DEBT. INTEREST MAY BE CHARGED AT A RATE OF 1.0% PER MONTH (12% ANNUALLY) FOR UNPAID BALANCES OVER THIRTY DAYS OLD. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF SAID BENEFITS. A COPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. I DO HEREBY CONSENT TO SUCH TREATMENT BY THE AUTHORIZED PERSONNEL OF THE BIOMECHANICS PHYSICAL THERAPY & SPORTS MEDICINE AS MAY BE DICTATED BY PRUDENT MEDICAL PRACTICE BY MY ILLNESS, INJURY OR CONDITION. THIS CONSENT IS INTENDED AS A WAIVER OF LIABILITY FOR SUCH TREATMENT EXCEPT ACTS OF NEGLIGENCE.

AUTHORIZED SIGNATURE	TODAYS DATE
----------------------	-------------

PATIENT/CLIENT MEDICAL HISTORY

Name: _____ Age: _____

Reason for visit:

Chief Complaint: Right Left

Date of Onset/Injury: ____/____/____ Work / Auto Related: Yes No (circle)
 Previous Surgeries/Dates of: _____
 Previous Physical Therapy/Dates of: _____
 Previous X-Rays/CT Scans/MRI's/Dates: _____
 Known Medical Allergies: _____

Are you currently taking any Medications? Yes No

Difficulties/Problems with any of the following please check all that apply.

Head		Heart		High Blood Pressure		Cancer	
Eyes		Lungs		Heart Attacks		Angina/Chest Pain	
Ears		Ulcers		Gall Bladder		Urinary Tract Infection	
Nose		Asthma		Passing Blood		Polio	
Throat		Bowels		Diabetes/hypoglycemia		Headaches	
Kidneys		Arthritis		Stroke		Allergies	

If you answered yes to any of the above, please give a brief explanation: _____

GENERAL HEALTH

Are you on a special diet prescribed by a physician?	YES	NO
Have you had any unexplained weight loss in the last month?	YES	NO
Do you exercise regularly?	YES	NO
Do you have difficulty sleeping?	YES	NO
Do you experience episodes of dizziness?	YES	NO
Do you have difficulty swallowing?	YES	NO
Have you noticed any lumps or thickening of skin or muscle on your body?	YES	NO

WORK ENVIRONMENT:

Occupation _____
 Does your job involve: (please mark)
 Prolonged sitting _____
 Prolonged standing _____
 Prolonged walking _____
 Use of large or small equipment _____
 Lifting, bending, twisting, climbing, turning, reaching (please circle all that apply)
 Other: _____
 Do you use any special supports: back cushion _____ neck cushion _____ Back brace/corset: _____
 Other: _____

PATIENT/CLIENT

SIGNATURE _____ DATE _____

Notice of Patient Information Practices

The BioMechanics Physical Therapy and Sports Medicine Legal Duty:

The Company is required by law to protect the privacy of your personal health information, provide this notice about our practices and follow the information practices that are described herein.

Uses and Disclosures of Health Information:

The BioMechanics Physical Therapy & Sports Medicine uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and in evaluating the quality of care we provide. For example we may use your personal health information to contact you to provide appointment reminders or information about treatment alternatives or other health related benefits that could be of interest to you.

The BioMechanics Physical Therapy & Sports Medicine may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, and for emergencies. We may provide de-identified information for research studies. We may also provide information as required by law.

In any other situations, we are to obtain your written authorization before disclosing your personal health information. If you chose to provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

The BioMechanics Physical Therapy & Sports Medicine may change its policy at any time. When changes are made a new Notice of Patient Information Practices will be posted in a common area of our clinic. You may also request an updated copy of the practices at any time.

Patients Rights:

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative operations except when specifically authorized by you, when required by law or in emergency situations. These requests will be considered on a case-by-case basis, but the Company is not legally required to accept them.

Concerns and Complaints:

If you are concerned that The BioMechanics Physical Therapy & Sports Medicine may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact clinic director or company owners. You may also send a written complaint to the US Department of Health and Human Services.

All Patients MUST receive a copy of this form.

The BioMechanics Physical Therapy & Sports Medicine
928-771-1700

Patient Information Consent Form

I have read and understand the Notice of Information Practice and understand that The BioMechanics Physical Therapy & Sports Medicine may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating quality of services provided and any administrative operations related to treatment of payment. I understand 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 company in writing. I also understand that The BioMechanics Physical Therapy & Sports Medicine will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I have received a copy of the Notice of Patient Information Practices and hereby consent to the use and disclosure of my personal health information for purposes as noted in the Notice of Information Practices. I understand I retain the right to revoke this consent by notifying the Company in writing at any time.

Print Name

Date

Patient Signature

Clinic Policies

Welcome to The BioMechanics Physical Therapy & Sports Medicine!

We are excited to assist you with your therapy; these are a few guidelines which will help you during your rehabilitation.

Appointments: It is important that you receive consistency of treatment and that you attend all appointments as scheduled. We will try to accommodate your schedule to our best ability and therefore ask you to schedule your full prescription frequency after your initial appointment. We ask that you please be on time for your appointments. If you are late for your appointment it will be up to the discretion of your therapist whether or not you will be seen and if you will get full or partial treatment. This is a courtesy to the other patients that are scheduled at their time.

Cancellation/ No-show: If you need to cancel we ask that you please call 24 hours prior to your scheduled time. We will try to accommodate and reschedule your appointment the same week if the schedule allows. If you fail to give notice this will count as a “no-show”, after two consecutive no-shows all further appointments will be deleted and the referring physician may be informed. We reserve the right to collect a \$20 *no-show fee* (this includes appointments not cancelled 24 hours in advance).

Compliance: We are obligated to inform your insurance company and physician if you are noncompliant. If you are a workman’s compensation patient we are also obligated to inform your case worker.

Benefits and Payments: We will try to verify benefits from your insurance company. However this is a quote from your insurance company and not a guarantee of benefits. Please be advised that any changes of your benefits are your responsibility and we ask you inform us if you receive information regarding changes. All co-pays, deductibles and co-insurances are due at time of service.

Attire: Loose fitting comfortable attire is recommended during treatment sessions.

We are committed to provide you with the highest quality of care. Open communication between you and your therapist is essential and if there is anything we can do to assist you further during this time, please don’t hesitate to let us know.

I have read and understand the policies of The BioMechanics Physical Therapy & Sports Medicine and will comply with the recommendations.

Patient signature: _____

Payment Policy

Please select from the following choices:

Primary Insurance

We will bill your primary insurance. We assume payment of insurance benefits is not forthcoming on charges older than sixty days. Charges outstanding for more than sixty days from the date of filing will be due in full from you regardless of the type of insurance involved. Any overpayments will be refunded after all charges have been processed by your primary insurance.

-Please be aware that we require payment for all co-pays, deductibles and percentages that your insurance will not cover at the time of service.

-All supplies are payable at the time of delivery and we will only file for supplies covered by your insurance carrier.

Secondary Insurance

As a courtesy to you we will bill secondary insurances upon request. The claim will be promptly submitted once payment from your primary insurance has been received.

Workers Compensation

We will bill your Worker's Compensation Carrier for your charges. Please note that you will remain financially responsible for any and all charges if your carrier denies coverage of your claim is contested.

Self Pay

Please pay the balances in full at the time of service. In the event you are unable to pay the balance in full, please advise us prior to the time of service. Please be advised that we are not a credit grantor, and therefore, failure to maintain these arrangements may result in the placement of your account with an agency or attorney for collection.

Please be aware that you will remain financially responsible for any and all services and supplies received regardless of the payment option selected above. In the event your account becomes delinquent and is therefore in default of payment, the patient, legal guardian, or admitting parent will be responsible for the principle amount owed and all reasonable costs associated with the collection of this debt, including, but not limited to, collection service fees, attorney's fees, all court costs, and additional legal expenses associated with recovery of the debt.

Thank you for allowing us the opportunity to service you. Please sign and date this form. If you have any questions, please ask for our assistance.

Signature: _____

Date: _____