Bryant Physical Therapy

Patient Information – Please Print Today's Date: _____ / _____ / _____

Name: _____ _____ _____
Last First M.I.

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Employer: _____ Occupation: _____

Gender: M or F Marital Status: M S W D

Date of Birth: _____ / _____ / _____ Social Security #: _____ - _____ - _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Person to Contact in Case of Emergency: _____

Relationship: _____ Phone #: _____

Name of Insured: _____ SSN: _____ - _____ - _____
DOB:
Parent's Name: _____ SSN: _____ - _____ - _____
(if minor) (if minor)

Description of Problem: _____

Is this related to?: Work Injury Auto Accident Other: _____

Date of Injury / Surgery: _____ Referring Physician: _____

Medicare Patients Only: Height = _____ feet / _____ inches Weight = _____ pounds

Are you currently receiving any type of services from a Home Health Agency? Yes or No

Are you currently receiving any type of services from a chiropractor? Yes or No

Have you received any physical therapy services this calendar year? Yes or No

I authorize the release of any information necessary to process any claim to my insurance company, and request payment to be made directly to Bryant Physical Therapy. I acknowledge that I am financially responsible for payment for all services rendered regardless of insurance coverage.

Signature: _____ **Date:** _____

MEDICAL HISTORY

Check Yes or No. If your answer is YES to any question, please provide explanation in the space provided.

YES	NO	
___	___	Do you have or have you ever had cancer? If yes, what year were you diagnosed? _____ What type and treatment for? _____
___	___	Do you have a history of arthritis? Type _____
		Joints Involved _____
___	___	Are you a diabetic? If yes, what type? _____ How is it being
		Treated? _____
___	___	Is there a family history for diabetes?
___	___	Do you have high blood pressure?
___	___	Do you have a heart condition?
___	___	Is there a family history for high blood pressure and/or heart conditions?
___	___	Do you have a thyroid condition?
___	___	Do you have a lung condition (including asthma, emphysema, bronchitis)?
___	___	Do you have a seizure disorder?
___	___	If you are post-menopausal, are you on hormone replacement therapy?
___	___	Have you been diagnosed with osteoporosis?
___	___	If applicable, are you or could you be pregnant?
___	___	Do you have a pacemaker?
___	___	Have you experienced a fall within the last three months?
___	___	Have you ever had a joint replacement? What joint(s)?_____
___	___	Do you currently have any implanted pins, rods or plates from surgery?
		If yes, where? _____
___	___	Do you have any allergies including allergies to medication or latex?
		If yes, what are they? _____

YES NO

___ ___ Did you or do you currently smoke or use tobacco products?

If yes, how many packs per day? _____ For how many years? _____

___ ___ Do you regularly consume alcohol? _____

___ ___ Did you once regularly consume alcohol? _____

___ ___ Are there other present or past medical conditions that you feel we should know about? _____

_____

Please list all surgeries and approximate dates of surgery

Procedure:	Year:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medications/Supplements

Please list all of the medications and supplements that you are currently taking.

Medication:	Reason For Taking Medication:

Financial Policy Statement

We bill your insurance carrier solely as a courtesy to you. ***We require that arrangements for payment of your estimated share be made today.*** In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to Bryant Physical Therapy.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

I have read and understand Bryant Physical Therapy's Financial Policy Statement.

Signature: _____ **Date:** _____

Acknowledgement of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of Bryant Physical Therapy's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that Bryant Physical Therapy has the right to change the *Notice of Privacy Practices* and that I may contact this office to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: _____ **Date:** _____