BULVERDE PHYSICAL THERAPY & WELLNESS CENTER

PATIENT INFORMATION

Last Name: First Name: Middle Initial:

Maiden: Suffix: DOB:

Gender: ☐ Male ☐ Female SSN: DL # & State

Mailing Address:

City: State: Zip:

Home Phone: Work: Cell:

Call 1st: ☐ Home ☐ Work ☐ Cell

EMPLOYER INFORMATION

Name: Occupation:

Address: City: State: Zip:

GUARANTOR/RESPONSIBILITY PARTY

(Parent/Guardian: Please complete if patient is a minor.)

Responsible party's name: Relationship to Patient:

Addrress: City: State: Zip:

SS # of Responsible party: DOB:

Home Phone: Work Phone: Cell:

INSURANCE COVERAGE - PRIMARY

Insurance Carrier: Policy Number:

Group Number: Effective Date: Expiration Date:

Policy Holders First/Last Name:

Policy Holders SSN: Policy Holders DOB:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent Policy Holders Employer:

INSURANCE COVERAGE – SECONDARY

Insurance Carrier: Policy Number:

Group Number: Effective Date: Expiration Date:

Policy Holders First/Last Name:

Policy Holders SSN: Policy Holders DOB:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent Policy Holders Employer:

IN CASE OF AN EMERGENCY, CONTACT

Name: Relationship to Patient:

Home Phone: Work: Cell:

HOW DID YOU HEAR OF US

(Circle one): Internet/Insurance/Friend/Employer/Phone Book/ Other:

Name of person who referred you, so we could thank them for your referral:

Please read before signing

CONSENT TO TREATMENT: I consent to rehabilitation and related services at Bulverde Physical Therapy. In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching and/or direct contact of sensitive nature.

TREATMENT OF MINORS: I, as parent/guardian of a minor receiving treatment here under, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.

LIABILITY: I know and agree that Bulverde Physical Therapy is not responsible for loss or damage to personal valuables.

WAIVER AND RELEASE: I hereby release, discharge, claim, demand and acquit Bulverde Physical Therapy, its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claims, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and/or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.

AUTHORIZING OF PAYMENT: I hereby assign all benefits directly to Bulverde Physical Therapy and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices.

**I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

Patient/Guardian Signature_____ Date:_____

BULVERDE PHYSICAL THERAPY & WELLNESS CENTER

FINANCIAL POLICY

Thank you for choosing Bulverde Physical Therapy as your Physical Therapy Provider. We are committed to providing the best possible care for you. In order to achieve this goal, we need your assistance in understanding our financial policy. Please understand that payment of your bills is considered part of your treatment. The following is a statement of our Financial Policy. Please read and sign prior to your treatment.

Payment of services is due prior to or upon completion of each treatment visit. We accept CASH, MASTERCARD, VISA, DISCOVER, AMERICAN EXPRESS, OR personal checks. Once your insurance information is on file, we will be happy to submit your claims to your Insurance company. _____Initial

PRIVATE INSURANCE

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that your insurance is a contract between you, your employer, and the insurance company. We are not party to that contract. We must emphasize that as your provider, our relationship is with you, and not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the dates of service rendered.

It is our policy to call and verify benefits and eligibility to estimate your payment portion. However, there is no guarantee from the insurance company of their payment amount. We may not know the exact amount due until the claim has been processed. At this point, there may be more due on your account. In this event, we will mail you a statement, and appreciate your prompt payment.

Regarding insurance plans where we are a participating provider, we will take the contracted rate assigned by the insurance company and make the proper adjustments to your claim. _____Initial

NON-COVERED EXPENSES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You may be responsible for payment of charges denied due to the insurance company's arbitrary determination of usual and customary rates. There may also be charges that your insurance does not cover due to limitations of your policy, or what they consider reasonable and necessary. It is your responsibility to know what the policy limitations are. Our goal is to improve your condition successfully based on what the doctor deems reasonable and necessary treatment, and not on what your policy limitations are. Therefore, unless you alert us prior to treatment, you will be financially responsible for non-covered expenses. _____Initial

MISSED APPOINTMENTS

Please be on time for your appointments so that you may be given the full benefit of your scheduled treatment. Late arrivals greater than 15 minutes may result in shortened treatment or cancellation. It is our policy to reschedule any cancelled appointments for the same week at t the time of your call. **There is a $20 charge for cancellation without a 24-hour notice**. Attending your scheduled appointments is crucial to successful treatment and recovery from you injury. _____Initial

INFORMATION

A final statement will be mailed to you once we have received all explanation of benefits from your insurance carrier. The balance due will be charged to your credit card on file, if payment is not received within fourteen days of notice. _____Initial

I give my permission to Bulverde Physical Therapy to release information, verbal and/or written, from my medical record to my physician, insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, or other assignees as it relates to my treatment. I further authorize Bulverde Physical Therapy to obtain medical records from my physician or other medical professionals as it relates to my treatment.

_____Initial

I have read, understand, and agree to this Financial Policy. I am also aware of, and understand my insurance benefits for treatment.

Patient/Guardian Signature_____ Date_____

BULVERDE PHYSICAL THERAPY & WELLNESS CENTER

PATIENT INFORMATION CONSENT FORM

Disclosure Authorization – For Release of Protected Health Information (PHI)

I have read and fully understand **Bulverde Physical Therapy's** Notice of Privacy Practices. A copy of the Notice of Privacy Practices is available in the front waiting area or a hard copy may be obtained upon request. I understand that Bulverde Physical Therapy 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 is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Bulverde Physical Therapy 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 **Bulverde Physical Therapy's** Notice of Privacy Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name: _____Date: _____ Initials: _____

Communication of Health Information

I give permission to Bulverde Physical Therapy to disclose and discuss any information related to my medical condition(s) with the following individuals:

Name: _____ Relationship_____Phone Number:_____
Name:_____Relationship_____ Phone Number:_____
Name:_____Relationship_____Phone Number:_____

Contact Information

Appointment Reminders: Voice / Text / E-mail (please circle one)

****** Would you prefer an electronic statement sent to you in the event if a balance is due: Y or N** (please circle one)

E-mail address you would like for statements or correspondence sent to:

_____@_____

Patient/Guardian Signature: _____ Date_____

BULVERDE PHYSICAL & THERAPY WELLNESS CENTER

MEDICAL HISTORY FORM

Patient Name: _____ Today's Date: _____
Are you presently working? ☐ Yes ☐ No Date of Injury:_____
Have you experienced these symptoms before? ☐ Yes ☐ No If yes, when?_____

****Indicate how you sustained this condition:**
Work Related Injury_____ Athletic/Recreation injury_____ Cause Unknown_____
Motor Vehicle Accident _____ Injury related to lifting _____ Recurrence of prior condition _____
Other:_____

If work related, describe how the injury occurred:_____.

Have you had surgery related to this condition? ☐ Yes ☐ No If yes, what type of surgery and when? _____
_____ Date of Surgery: _____

Are you presently taking medication? ☐ Yes ☐ No If yes, please list and specify condition(s):
_____
_____

What specific activities are you having difficulties with? _____

What are your personal goals you hope to achieve from physical therapy? _____
_____

Have you had any physical therapy, occupational therapy, or chiropractic care for this condition? ☐ Yes ☐ No
If yes, please explain: _____

PLEASE CHECK IF YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

__Diabetes
__Chest pain/Angina
__Heart Disease
__High Blood Pressure
__Heart Attack
__Pacemaker
__Vascular Disease
__CVA/Stroke/TIA
__Seizures
__Skin Abnormalities
__Sexual Dysfunction
__Nausea/Vomiting
__COPD
__Thyroid Problems
__Osteoporosis/Osteopenia
__Arthritis
__Hernia
__Recent Fractures
__Headaches
__Dizziness/Fainting
__Liver/Gallbaldder Problems
__Kidney Problems
__Bowel/Bladder Problems
__Metal Implants
__Ringing in your ears
__MRSA
__Special dietary Guidelines
__HIV
__Hepatitis
__Asthma
__Depression
__Anxiety
__Allergies: _____
__Cancer:_____
__Are you Pregnant? ☐ Yes ☐ No
__Do you smoke? ☐ Yes ☐ No

If you answered YES to any of the above, please explain and give approximate dates: _____
_____
Please list any other surgeries you have had, including type and date: _____
_____
Do you participate in any sports, exercise programs, or activities on a regular basis? ☐ Yes ☐ No
If yes, please describe: _____
Is there any other information regarding your past medical history that we should know about?_____
_____

Patient/Guardian Signature: _____ Date:_____

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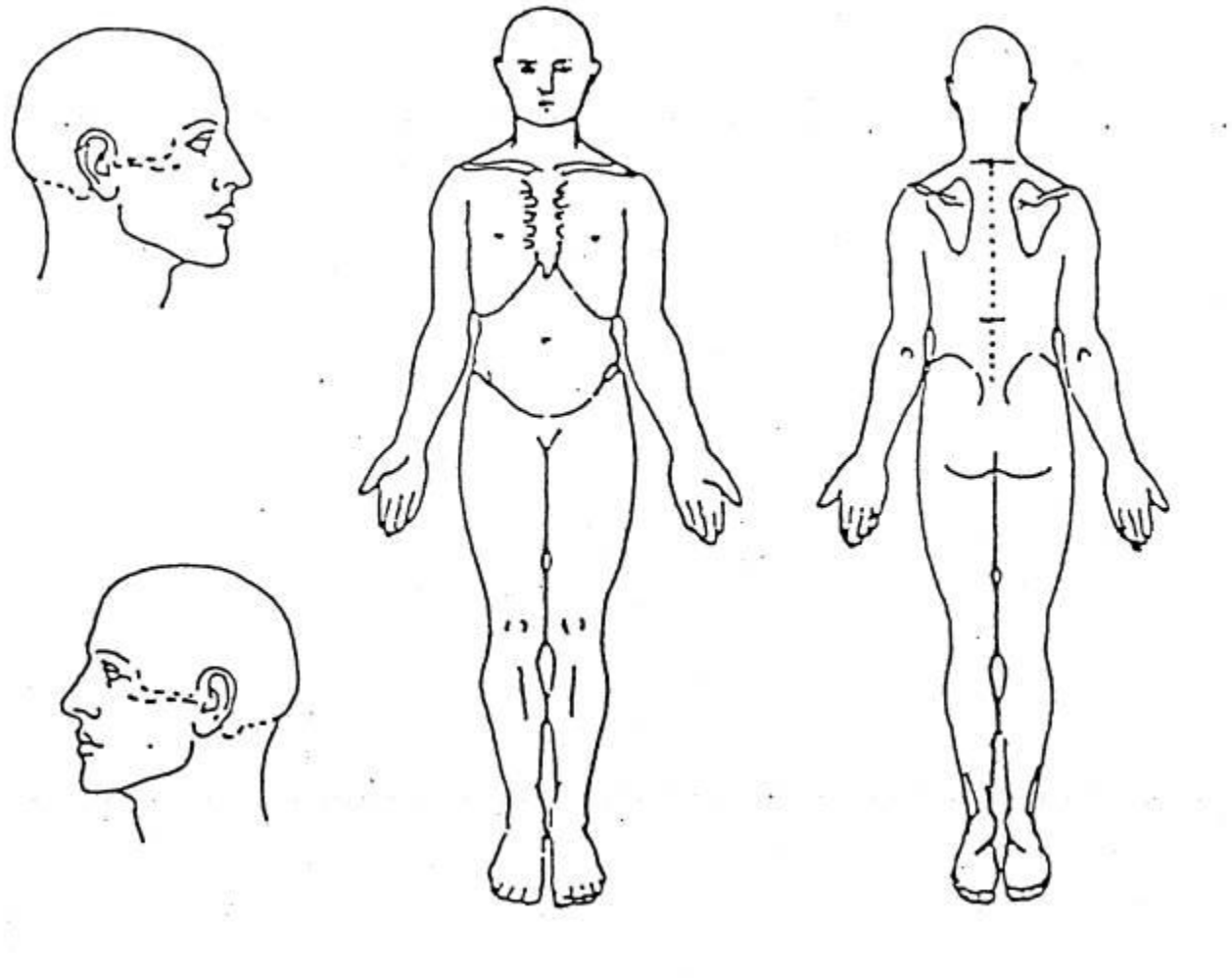
MEDICAL HISTORY FORM – CONTINUED

Please indicate below where your symptoms are located:



Please circle the appropriate number that best describes your pain level:

0	No pain
1	Mild Pain; you are aware of it, but it doesn't bother you
2	Moderate Pain that you can tolerate without medication
3	Moderate pain that requires medication
4-5	More Severe Pain; you begin to reduce your activity level
6	Severe pain
7-9	Intensely Severe Pain
10	Most Severe Pain; it may require a visit to the Emergency Room

Patient/Guardian Signature: _____ Date:_____

Therapist Signature: _____ Date: _____