BLACK ROCK
Physical Therapy

PATIENT INFORMATION

TODAY'S DATE _____

NAME _____ DATE OF BIRTH _____

EMAIL _____ SS# (OPTIONAL) _____

ADDRESS _____ CELL PHONE _____

_____ HOME PHONE _____

EMPLOYER _____ OCCUPATION _____

ADDRESS _____ WORK PHONE _____

_____

PCP _____ PHONE _____
(PRIMARY CARE PHYSICIAN)

ADDRESS _____

INSURANCE COMPANY _____ PROVIDER PHONE _____

POLICYHOLDER NAME _____ POLICYHOLDER D.O.B. _____

MEMBER ID# _____ PLAN TYPE (HMO, PPO, ETC) _____

EMERGENCY CONTACT _____ PHONE _____

RELATIONSHIP _____

HOW DID YOU HEAR ABOUT US? _____

CONSENT

I understand I am responsible for notifying BRPT of changes in my medical status and personnel.

I authorize Black Rock Physical Therapy, LLC to furnish full details of my medical care to my physician, insurance company and attorney (if applicable) and to request any records pertaining to my care.

SIGNATURE _____

If under age 18, parent/guardian signature

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MEDICAL HISTORY

___ ALLERGIES, ASTHMA, HAY FEVER
___ BLADDER INFECTIONS
___ BREATHING DIFFICULTY
___ CANCER
___ CHEST PAIN
___ CHILDHOOD ORTHOPEDIC CONDITIONS
___ CONCUSSION / HEAD TRAUMA
___ DIABETES
___ DIZZINESS
___ EDEMA (REGIONAL SWELLING)
___ EPILEPSY
___ FATIGUE
___ GASTROINTESTINAL ISSUES
___ GYNECOLOGICAL ISSUES
___ HEART DISEASE
___ HEADACHE / MIGRAINE
___ HEPATITIS / JAUNDICE
___ HIGH BLOOD PRESSURE
___ HOT / COLD INTOLERANCE
___ KIDNEY DISEASE
___ LYME DISEASE
___ OSTEOPOROSIS
___ PACEMAKER
___ PHLEBITIS
___ PSYCHIATRIC (ANXIETY, DEPRESSION, ETC.)
___ SKIN (SENSITIVITY, RASHES, WOUNDS)
___ THYROID CONDITION
___ VASCULAR CONDITION
___ WEIGHT CHANGE
___ OTHER

MEDICATION / SUPPLEMENTS:

NAME	AMOUNT	CONDITION

ARE YOU CURRENTLY PREGNANT OR PLAN TO BE? _____YES _____ NO _____ N/A

HAVE YOU EVER HAD SURGERY OR BEEN HOSPITALIZED? EXPLAIN.

_____

_____

ARE YOU PRESENTLY OR HAVE YOU BEEN INVOLVED IN AN EXERCISE PROGRAM? PLEASE DESCRIBE.

_____

_____

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TODAY'S VISIT

REFERRING MD (IF APPLICABLE) _____ **PHONE** _____

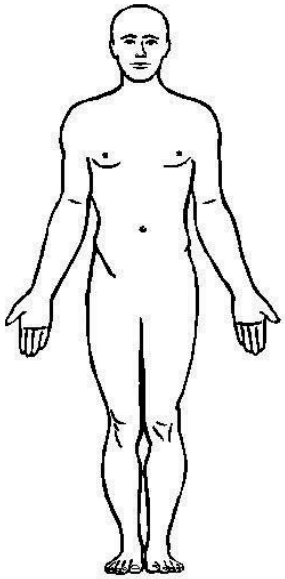
ADDRESS _____

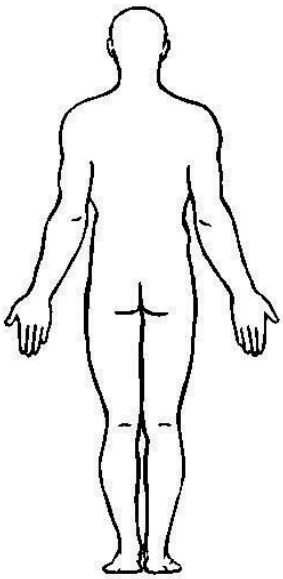
ANY OTHER HEALTH PROFESSIONALS CONSULTED FOR THIS PROBLEM _____

_____

BODY CHART

PLEASE MARK THE AREAS OF YOUR BODY WHICH ARE EXPERIENCING SYMPTOMS BY DRAWING SYMBOLS ON THE FIGURE KEYED TO THE CONDITIONS ON THE RIGHT (PAIN, ETC.)





_____ = PAIN

_____ = PINS AND NEEDLES

_____ = NUMB / COLD

_____ = TIGHT/ STIFF

_____ = OTHER (DESCRIBE)

WHEN DID SYMPTOMS START _____ **WORK INJURY?** _____ **AUTO INJURY?** _____

LIST THE GOAL(S) YOU'D LIKE TO ACCOMPLISH THROUGH PHYSICAL THERAPY:

_____

_____

ANYTHING ELSE WE NEED TO KNOW?

_____

_____

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FINANCIAL POLICY

Thank you for choosing Black Rock Physical Therapy! We are committed to providing you with the best possible care and charging reasonable fees. We ask that you please read and acknowledge our Financial Policy.

GENERAL

Payment for treatment is due at the time of service.

INSURANCE

We participate with Medicare & Anthem Blue Cross/Blue Shield. All other insurance plans are considered out-of-network. Please present your insurance card on your first visit. If your insurance or billing information changes, notify us at your next visit.

As a courtesy to you, we will contact your insurance provider to verify your physical therapy benefits, however the information we receive is not always accurate. Patients are responsible for their health care charges and should be familiar with the policies of their insurance provider. We encourage you to contact them directly to understand your PT benefits.

IN-NETWORK (MEDICARE, ANTHEM BC/BS, UNITEDHEALTHCARE, OXFORD)

If your plan has a co-pay, it is due at the time of service. All deductibles and co-insurance will be billed to you once the claim has been submitted and insurance adjudicates. You are responsible for the approved amount not paid by insurance.

OUT-OF-NETWORK (ALL OTHERS)

Payment towards your deductible is due at the time of service. One of the benefits we provide is we will file/submit your out-of-network claim with your insurance company so that charges accrued will go towards your out-of-network deductible.

Once that deductible has been met, we will collect a nominal amount at the time of your visit toward any co-pays and/or co-insurance, and you will be responsible for any additional charges according to the terms of your plan. You will receive a bill for those charges.

SELF PAY or NO INSURANCE

Payment is due at the time of service. NO insurance claims will be filed by us. You will receive a receipt at time of payment. If you would like to self-submit, please request a Superbill.

PAYMENT METHODS

We accept cash, check and credit card (Visa, MasterCard, AMEX, Discover).

CANCELLATION POLICY

Please give 24 hours notice if you cannot keep your appointment. A $50 cancellation fee may be assessed for cancellations made within 24 hours or for failure to show (except in cases of emergency or illness).

I understand and agree to the terms of the Financial Policy as stated above.

Signature _____ Date _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Privacy Officer: Christine Brown

Name of Patient _____

I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signed _____ **Date** _____

Print Name _____ **Relationship** _____
(if other than patient)

For office use only:

_____ Signed form received by _____

_____ Acknowledgement refused:

Efforts to obtain _____

Reasons for refusal _____

HIPAA Updated 2012