Building Bones and Balance, LLC
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Physical Therapy and Rehab
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Patient Information

Please Print

Date:_____

Patient Name:_____

Address:_____ City:_____ State:_____Zip:_____

Age: _____ Sex: Female Male Date of Birth:_____ SS#: _____

Email:_____

Home Phone #: (_____)_____Cell Phone #: (_____)_____Work Phone #: (_____)_____

Emergency Contact Name:_____ Relation: _____ Phone:_____

Accident Information

Is Condition due to an accident? Yes No Type of Accident: Auto Work Home Other

Employer Name and Address: _____ Occupation:_____

Accident Contact: Auto Insurance Employer Workers Comp Other Attorney's Name:_____ Phone:_____

Health Insurance Information

Primary Carrier Name: _____

Address and Phone: _____

ID#: _____Group#:_____

Secondary Carrier Name:_____

Address and Phone: _____

ID#: _____Group#:_____

Reason for Visit

When did your symptoms appear?_____ Is this condition getting progressively worse? Yes No

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

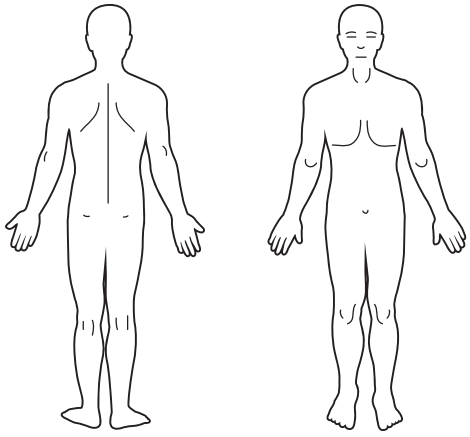
Type of Pain: Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____ Is it constant or does it come and go? _____

Does it interfere with **(Circle all that apply)** Work Sleep Daily Routine Recreation

Activities or movements which are painful to perform? **(Circle all that apply)** Sitting Standing Walking Bending Lying Down

Please mark on this diagram where you feel pain.



MEDICAL HISTORY								
	Y	N		Y	N		Y	N
High/Low Blood Pressure			Parkinson's Disease			Macular Degeneration		
Coronary Artery Disease			Asthma			Osteoarthritis		
Aortic Aneurysm			Shortness of Breath			Rheumatoid Arthritis		
Peripheral Vascular Disease			Emphysema			Fibromyalgia		
Heart Attack			Cancer			Psoriasis/Eczema		
Arhythmia			Kidney Disease			Lupus		
Seizure Disorder			Urinary Tract/Disease			HIV positive/AIDS		
Stroke (CVA or TLA)			Prostate Disease			Osteoporosis/ Osteopenia		
Neuropathy			GI Problems/Disease			Fractures		
Diabetes			Ulcer			Spinal Stenosis		
Hypoglycemia			Diverticulitis			Degenerative Disc Disease		
Hypothyroidism/Hyperthyroidism			Liver Disease			Disc Herniation/ Bulge		
Vertigo			Gall Bladder Disease			Difficulty hearing?		
Balance Problems - Inner Ear			Headaches (Tension/Migraine)			Difficulty seeing?		
Balance Problems - Other			Glaucoma			Other:		

SURGICAL HISTORY								
	Y	DATE		Y	DATE		Y	DATE R/L
Tonsillectomy			Angioplasty			Cervical Surgery		
Appendectomy			Pacemaker			Lumbar Surgery		
D & C			Thyroid			Shoulder Surgery		
Hysterectomy			Gall Bladder			Elbow Surgery		
C-Section			Liver			Wrist Surgery		
Mastectomy R/L			Kidney			Hand Surgery		
Breast Reconstruction R/L			Gastrointestinal			Hip Surgery		
Breast Augmentation R/L			Bariatric Bypass			Knee Surgery		
Prostate			Cataract R/L			Ankle Surgery		
Cardiac Bypass			Eye - Other R/L			Foot Surgery		
Cardiac Catheter					Other:			

SOCIAL HISTORY							
	Y	N	OCC		Y	N	OCC
Do you have stress?				Do you drink?			
Do you smoke?				Do you exercise?			

MEDICARE ONLY
Self-Related Health (at the present time): Excellent Very Good Fair Poor
Where do you plan to live at the conclusion of outpatient physical therapy?
Who do you plan to live with at the conclusion of outpatient physical therapy?

Allergies/Medicine:_____ Allergies/Other:_____

_____ _____

Signature *Date*

Medication Profile

Name: _____ Date: _____

Physician: _____

Allergies: _____ Weight: _____ Height: _____

Pharmacy: _____ Phone: _____

Medication	Dosage/Route	Frequency	Purpose

Authorization/Consent/Financial Policy

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

Building Bones and Balance, LLC is hereby authorized to disclose all or any part of the medical record of the patient named in the registration to such insurance companies or agencies as may be concerned with the payment of professional and/or facility costs of the patient named on this registration. The authorization is effective for three years from the date of service and may be revoked with written notification.

CONSENT FOR MEDICAL TREATMENT

The undersigned hereby consents to any therapy, treatment, or facility services rendered to the patient under the general and special instructions of the therapist assigned to care for me. I also acknowledge that no guarantee or warranty has been made by said therapist of Building Bones and Balance, LLC as to the results of any treatment given or performed.

MEDICARE

Building Bones and Balance, LLC accepts Medicare. This means that we will accept the Medicare approved amount as payment in full for our services. We will bill Medicare and your supplemental insurance company as a courtesy to you. Medicare will pay 80% directly to us and the other 20% must be collected from the patient or from your supplemental insurance company. The Health Care Financing Administration (HCFA) of the United States Government has issued a warning that providers who waive the co-insurance charge or the annual deductible for Medicare are subject to prosecution for fraud. We, therefore, must collect the deductible and the remaining 20%. If your supplemental insurance company does not pay or if your Medicare deductible has not been met, you will receive a statement from us indicating the amount you owe. Dressings and supplies will not be covered by Managed Care Organizations or Medicare. Therefore, you will be financially responsible for these items at the time of service.

WORKERS' COMPENSATION

If you are a patient with a valid Workers' Compensation claim, we will bill your employer's insurance carrier for reimbursement on all treatment rendered. If you have reached maximum medical improvement as deemed by the insurance carrier, you will be responsible for a co-payment for each visit.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

SCHEDULING AND MISSED APPOINTMENTS

It is the patient's responsibility to make and confirm their appointments (date and time). We are unable to guarantee standing appointments but will make every effort to schedule appropriately so that a patient never has an extended wait to see a therapist. If you are unable to attend an appointment, we ask that you call 24 hours from your scheduled appointment time in advance to let us know. By calling us, you will allow us to make the appropriate changes to the schedule. ***A $75 cancellation fee will be charged for missed appointments without 24 hour notice.***

INSURANCE

Billing insurance is done as a courtesy to the patient and does not dismiss the patient's responsibility for payment in full. Some companies will pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is the patient's ultimate responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance company. Regarding insurance plans where we are a participating provider all co-pays and deductibles are due prior to treatment. Payments sent to the patient must be forwarded to the provider upon receipt. **By my signature below, I recognize, understand and accept that I am ultimately financially responsible for any and all charges for services rendered by including, but not limited to, any services or fees not covered or denied by my insurance company.** Additionally, I agree to pay all charges associated with the cost of collection, if my account becomes delinquent, including reasonable attorney's fees, court costs, finance charges and the legal rate of interest on the account until paid in full.

MEDICAL EMERGENCIES

In the event of a medical emergency, it is our policy to call 911.

I certify that I have read and understand fully the above information.

_____	_____	_____
Signature of Patient or Responsible Party	Print Name	Date
_____	_____	_____
Signature of Parent or Guardian	Print Name	Date

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1) Uses and Disclosures We will use your protected health information (PHI) for the purposes of treatment, payment and health care operations.

Treatment includes the disclosure of health information to other providers who have referred you for services or are involved in your care. This may include doctors, nurses, technicians and other physical therapists. For example, we may feel that a stroke patient we are treating would benefit from an evaluation by a speech-language pathologist to address a swallowing difficulty. The health information we share with the speech-language pathologist would be considered a treatment related disclosure.

Payment includes the disclosure of health information to your insurance company, including Medicare and Medicaid, so payment can be obtained for services rendered. Your insurance company may make a request to review your medical record to determine that your care was necessary.

Health Care Operations includes the utilization of your records to monitor the quality of care being given at our facility or for business planning activities.

Other Special Uses
Our practice may use your PHI to send you an appointment reminder, to inform you of our other health-related products and services, or to request a contribution to our charitable activities.

Uses and Disclosures Required by Law
The federal health information privacy regulations either permit or require us to use or disclose your PHI in the following ways: we may share some of your PHI with a family member or friend involved in your care if you do not object, we may use your PHI in an emergency situation when you may not be able to express yourself, and we may use or disclose your PHI for research purposes if we are provided with very specific assurances that your privacy will be protected. We may also disclose your PHI when we are required to do so by law, for example by court order or subpoena. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions. We may use and disclose health information about you to avert a serious threat to your health or safety or the health or safety of the public or others. If you are in the Armed Forces, we may release health information about you when it is determined to be necessary by the appropriate military command authorities. We may also release information about you for workers' compensation or other similar programs that provide benefits for work-related injury or illness. Your authorization is required before your PHI may be used or disclosed by us for other purposes.

2) Your Privacy Rights

Restrictions

You have the right to request restrictions on how your PHI is used; however, we are not required to agree with your request. If we do agree, we must abide by your request.

Confidential Communications
You have the right to request confidential communication from us at a location of your choosing. This request must be in writing.

Access to PHI
You have the right to request a copy of your medical record. You must make this request in writing and we may charge a fee to cover the costs of copying and mailing.

Amendments
You have the right to request an amendment be made to your PHI, if you disagree with what it says about you. This request must be made in writing. If we disagree with you, we are not required to make the change. You do have the right to submit a written statement about why you disagree that will become part of your record. We may not amend parts of your medical record that we did not create.

Accounting of Disclosures
After April 14, 2003, you have the right to request an accounting of the disclosures made in the previous six years. These disclosures will not include those made for treatment, payment, or health care operations or for which we have obtained authorization.

Complaints
If you feel that your privacy rights have been violated, you have the right to make a complaint to us in writing without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services.

Our Duty to Protect Your Privacy
We are required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document, our Notice of Privacy Practices. We reserve the right to update this notice if required by law. If we do update this notice at any time in the future, you will receive a revised notice when you next seek treatment from us.

I have read and understand my rights of privacy.

_____

Signature of Patient Date

Pain Disability Index

Patient name:_____ Age: _____ Height:_____ Weight: _____

Pain Disability Index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. A source of 0 means no disability at all, and a score of 10 signifies that all the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family/Home Responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school).
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7__. 8__. 9__. 10__. Worst Disability

Recreation: The disability includes hobbies, sports, and other similar leisure time activities.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7__. 8__. 9__. 10__. Worst Disability

Social Activity: This category refers to activities, which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7__. 8__. 9__. 10__. Worst Disability

Occupation: This category refers to activities that are partly of our directly related to one's job. This includes non-paying jobs as well, such as that of a housewife or volunteer.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7__. 8__. 9__. 10__. Worst Disability

Sexual Behavior: This category refers to the frequency and quality of one's sex life.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7__. 8__. 9__. 10__. Worst Disability

Self Care: This category includes activities, which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed, etc.)
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7__. 8__. 9__. 10__. Worst Disability

Life-Support Activities: This category refers to basic life supporting behaviors such as eating, sleeping and breathing.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7__. 8__. 9__. 10__. Worst Disability

Signature_____Please Print_____

Date_____