PATIENT INFORMATION

Name:_____ ☐ Male ☐ Female
First MI Last

Date of Birth_____/____/____Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address:_____
Street Address City State Zip

Email Address:_____

Cell Phone:(___)_____

Would you like to receive appointment reminders by email?

☐ Yes, notify me by email ☐ No, do not email me

Would you like to receive appointment reminders by text?

☐ Yes, notify me by text ☐ No, do not text Me

Emergency Contact:_____Phone: (_____) _____-_____Relation:_____

Employer:_____

Occupation:_____
(REQUIRED FOR WORKER COMPENSATION CASES)

Have you had Physical or Occupational Therapy this year for any condition? ☐ Yes ☐ No

PHYSICIAN INFORMATION

Referring Physician:_____Ctiy_____

CONSENT FOR TREATMENT

I the Undersigned do hereby agree and give my consent for **Beachside Physical Therapy** to furnish physical therapy care and treatment considered necessary and proper in evaluating and/or treating my physical condition. It is your responsibility to notify our office of any patient information changes (i.e., address, phone number, name, insurance information, etc.)

Signature:_____ Date:_____
(PARENT OR GUARDIAN MUST SIGN FOR PATIENTS UNDER 18 YEARS OF AGE)

Relationship to Patient: ☐ Self ☐ Mother ☐ Father ☐ Legal Guardian

FINANCIAL POLICY AND INSURANCE INFORMATION

I understand and agree that insurance claim forms will be submitted to my insurance company as a matter of convenience only, and that I am responsible for all charges regardless of my existing medical coverage. If I do not provide insurance information or inaccurate information, Beachside Physical Therapy will bill me directly for incurred charges, as well as for charges not covered by my insurance plan. If I receive a notice from my insurance company that payment is delayed or denied because additional information is required, I will contact my insurance company so that claims may be reprocessed and paid. I also authorize Beachside Physical Therapy to furnish information to insurance carriers concerning this treatment.

I hereby give authorization for payment of insurance benefits made directly to BPT for services rendered. In the event that my insurance company forwards payment directly to me, instead of BPT, I will immediately deliver said payment to BPT. I understand and agree that I am wholly responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due upon demand. I understand and agree that if it becomes necessary to commence legal actions for the collection of outstanding charges on my account, I will be responsible for any costs and/or court fees, in addition to the outstanding balance. If I receive payment from the settlement, I will release funds to Beachside Physical Therapy immediately.

Signature of Person Responsible for Charges:_____Date:_____

(PARENT OR GUARDIAN MUST SIGN FOR PATIENTS UNDER 18 YEARS OF AGE)

Relationship to Patient: ☐ Self ☐ Mother ☐ Father ☐ Legal Guardian

PRIMARY INSURANCE

Name of Subscriber:_____ _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Insurance Co:_____

Member ID #:_____Group#/Name:_____

(Social Security is REQUIRED Tricare/Triwest)

SECONDARY INSURANCE

Name of Subscriber:_____Date of Birth___/____/____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Insurance Co:_____Phone: (_____) _____-_____

Subscriber #:_____Group#/Name:_____

(Social Security is REQUIRED Tricare/Triwest)

Please understand that this is not a promise to pay by your insurance carrier. Claims will be reviewed by your carrier for eligibility and benefits and may be subject to limitations and exclusions.

INITIAL: _____ We have contacted your insurance carrier to verify your eligibility and benefits for outpatient physical therapy, occupational or speech therapy. We highly recommend that you also verify your benefits with your carrier. You are responsible for any services/charges not covered by your insurance plan, regardless of what was quoted to us by your carrier.

INITIAL: _____ If you have a deductible and/or co-insurance, we have no way of knowing exactly what your portion will be until your carrier processes the claims. We request that you pay your estimated deductible and estimated co-insurance when services are rendered. As we are only able to provide an estimate, you may receive statements after your claims are processed by your insurance carrier. Should you have a specific co-payment, we require that it be paid at the time services are rendered.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION OF RELEASE OF SPECIFIC INFORMATION

Beachside Physical Therapy reserves the right to modify the privacy practices outlined in this notice.

I acknowledge that I have received or have had the opportunity to receive a copy of the official Notice of Privacy Practices from Beachside Physical Therapy, Inc.

Signature:_____Date:_____
(PARENT OR GUARDIAN MUST SIGN FOR PATIENTS UNDER 18 YEARS OF AGE)

Relationship to Patient: ☐ Self ☐ Mother ☐ Father ☐ Legal Guardian

Patient Name (Printed) _____

Initial all statements that apply:

_____ I authorize you to leave messages regarding my appointments on my answering machine or voicemail as listed on my patient information.

_____ I authorize you to discuss my appointments with my emergency contact as listed on my patient information.

_____ In addition to my referring doctor, I authorize you to communicate with and send reports & evaluations to the following:

_____ I agree to enroll in the electronic statement service and consent to receive my periodic account statements electronically

HEALTH HISTORY

Patient Name:_____ Date of Birth_____/_____/___

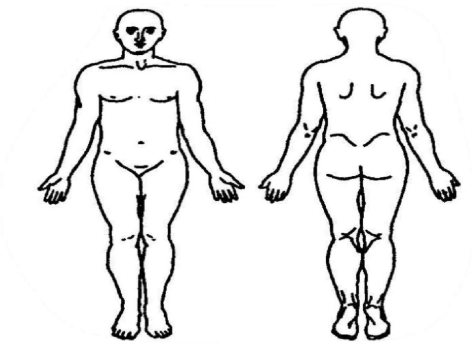
CURRENT COMPLAINTS

Date of Surgery(if reason for visit)_____

Briefly explain why you are here_____

Have you ever had a similar injury/condition in the past? YES NO (Circle one)

Is your injury/condition **getting better**, **staying the same**, or **getting worse**? (Circle one)

Please mark **X**'s on the figure where your current symptoms are located	Please circle your current symptoms below
	Sharp Aching Numbness Tingling Pulling Burning Dull Heavy Tight Shooting Throbbing Stabbing Other:_____

Rate your current pain level over the last week at its best and at its worst on the scale below

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 **UNBEARABLE PAIN**

On the percentage scale below, circle your current level of overall function

NO RESTRICTIONS 100% 90% 80% 70% 60% 50% 40% 30% 20% 10% 0% **UNABLE TO FUNCTION**

Do you have any work restrictions ☐ Yes ☐No
If no, please list any specific limitations you have due to your current condition:_____

Beachside Physical Therapy

MEDICAL HISTORY

Please circle YES for applicable conditions. Or NO for all conditions.

Allergies	**Yes**	**No**	**Diabetes**	**Yes**	**No**	**Metal Implants**	**Yes**	**No**
Anemia	**Yes**	**No**	**Dizzy Spells**	**Yes**	**No**	**MRA**	**Yes**	**No**
Anxiety	**Yes**	**No**	**Emphysema/Bronchitis**	**Yes**	**No**	**Multiple Sclerosis**	**Yes**	**No**
Arthritis	**Yes**	**No**	**Fibromyalgia**	**Yes**	**No**	**Muscular Disease**	**Yes**	**No**
Asthma	**Yes**	**No**	**Fractures**	**Yes**	**No**	**Osteoporosis**	**Yes**	**No**
Autoimmune Disorder	**Yes**	**No**	**Gallbladder Problems**	**Yes**	**No**	**Parkinsons**	**Yes**	**No**
Cancer	**Yes**	**No**	**Headaches**	**Yes**	**No**	**Rheumatoid Arthritis**	**Yes**	**No**
Cardiac Conditions	**Yes**	**No**	**Hearing Impairment**	**Yes**	**No**	**Seizures**	**Yes**	**No**
Cardiac Pacemaker	**Yes**	**No**	**Hepatitis**	**Yes**	**No**	**Smoking**	**Yes**	**No**
Chemical Dependency	**Yes**	**No**	**High Cholesterol**	**Yes**	**No**	**Speech Problems**	**Yes**	**No**
Circulation Problems	**Yes**	**No**	**High/Low Blood Pressure**	**Yes**	**No**	**Strokes**	**Yes**	**No**
Covid-19	**Yes**	**No**	**HIV/AIDS**	**Yes**	**No**	**Thyroid Disease**	**Yes**	**No**
Currently Pregnant	**Yes**	**No**	**Incontinence**	**Yes**	**No**	**Tuberculosis**	**Yes**	**No**
Depression	**Yes**	**No**	**Kidney Problems**	**Yes**	**No**	**Vision Problems**	**Yes**	**No**

Describe any other conditions:

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions

Medical Precautions:

FALL HISTORY

Injury as a result of a fall in the past year?	☐ Yes	☐ No	Date of Fall: _____
Two or more falls in the last year? Patient is at risk for fall? Yes No N/A	☐ Yes	☐ No	Dates of Falls: _____

SURGICAL HISTORY

related to the current condition

Body Region:_____Surgery Type:_____Date of Surgery:_____

Body Region:_____Surgery Type:_____Date of Surgery:_____

Body Region:_____Surgery Type:_____Date of Surgery:_____

CURRENT MEDICATIONS

Drug	Dosage	Frequency	Route	Reason for Taking