



Date: _____ Date of treatment: _____

Patient Information

Last Name: _____ First Name: _____ Middle: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security #: _____ Date of Birth: _____ Age: _____

Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Diagnosis: _____ Date of Injury: _____ Post Op: Y / N

Primary Care Physician: _____ Referring Physician: _____

Date Last Seen by Referring Physician: _____ Date of Next Physician Appt: _____

How did you know about our office? _____

Have you had PT/OT/ST prior this year? If Yes, When: _____ Please call your insurance to confirm remaining benefits. Insurance companies will not provide us with this information. Let us know by YOUR NEXT APPOINTMENT.

Billing Information: Medical Insurance: _____ Motor Vehicle: _____ Work Comp: _____ Other: _____

Health Insurance (subscriber info)

Insurance Company _____ Insurance Subscriber _____

ID #: _____ Group # _____ Date of Birth _____

Social Security # of Insurance Subscriber: _____

Worker's Comp - MVA - Liability *(please circle)*

Insurance Company: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Claim #: _____

Adjustor: _____ Nurse Case Manager: _____

Attorney: *(If there is a legal case, please provide a letter of protection.)*

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Misc. Info: _____

RESPONSIBLE PARTY INFORMATION (If patient is under 18 years of age)

Name of Responsible Party: _____ SS#: _____ DOB: _____

Employer _____ Work Number _____

I (_____) give permission to Bodywise Physical Therapy to treat my child that would include any treatment/modalities that the doctor may prescribe.

Medications: _____

If female, are you pregnant? _____ Surgeries: _____

Allergies: _____ Other: _____

Please check any condition that applies to you:

- | | | | | | | |
|---|--|--|--|--|---|-------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Hernia | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Migraine | <input type="checkbox"/> Stroke | <input type="checkbox"/> Pace Maker |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Swollen Legs | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Light Headedness | |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Difficulty Sleeping | | |

Emergency Contact Information

Name _____ Relationship _____

Phone # _____

I give permission to Bodywise Physical Therapy to render treatment as needed. Initial: _____ Date: _____

RECORD RELEASE

I give permission to Bodywise Physical Therapy to release my therapy records to my physician, insurance company, or other related parties (case nurse). Initial: _____ Date: _____

I give consent to release any medical records to Bodywise Physical Therapy that is necessary to aid in my treatment. Initial: _____ Date: _____

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature authorizes Bodywise Physical Therapy to submit claims for benefits for services rendered, or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or my dependents. And that this signature will bind me as though the undersigned had personally signed the particular claims.

I hereby authorize (name of insurance co.) _____ to pay and hereby assign directly to Bodywise Physical Therapy all benefits, if any, otherwise payable to me for therapy services rendered. I understand that I am responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Bodywise Physical Therapy will be credited to my account. Initial: _____ Date: _____

I have received a copy of the Patient Bill of Rights Initial: _____ Date: _____

I have received a copy of the Privacy Notice Policy Initial: _____ Date: _____

I understand that my initials are equivalent to my signature.

Signature _____ Date: _____