B BODYSET Physical Therapy

Patient Intake
CaseID:

Patient Information

FIRST NAME: ______ LAST NAME: ______

ADDRESS: ______ GENDER: ______

______ BIRTH DATE: (MM/DD/YYYY) ____ ____ ____

______ ____ ______ SSN: ______

Phone (Home): ______ Referring Phys: ______

Phone (Other): ______ Primary Phys: ______

Email: ______

Employer: ______ Employer Phone: ______

Emergency Contact ______ CAR ACCIDENT YES NO

Date of Accident: ______

Insurance Information

Name of Policy Holder: ______ Birth Date of Policy Holder: ____ ____ ____

Relationship: ______ Attorney Name: ______

Attorney Firm Name: ______ Phone: ______

Case Manager (CM): ______ CM Phone: ______

CM Email: ______

Primary Insurance Information

Insurance Name: ______ Relationship with Subscriber: ______

POLICY # ______ GROUP # ______

Subscriber Name: ______ Subscriber Date of Birth: ______

Secondary Insurance Information

Insurance Name: ______ Relationship with Subscriber: ______

POLICY # ______ GROUP # ______

Subscriber Name: ______ Subscriber Date of Birth: ______

Patient Signature: ______ Date: ______

Patient Health Questionnaire

Height: _____ ft _____ in Weight: _____ lbs

Body Part & Side : ____________________

(Example: Knee - Right Side)

Symptoms

What problem(s) are you being treated for today? (Describe type and location of symptoms)

____

What date (roughly) did your present symptoms start? ____________________

How did your problem(s) begin? ____________________

Have you had surgery for this injury? ☐ Yes ☐ No Number of surgeries _____ Type of surgery ____________

PAIN ASSESSMENT											
Please report a pain assessment on the scale below where 0 is no pain and 10 is the worst pain imaginable.											
	N/A	1	2	3	4	5	6	7	8	9	10
Pain at Rest											
Pain with Activity											

FUNCTIONAL PROBLEMS	
Please list any and all functional problems you currently have due to your diagnosis.	
1	

Have you had any of the following medical or rehabilitative for this injury/episode? Check all that apply:

Chiropractor	☐	General Practitioner	☐
Massage Therapy	☐	MRI	☐
Occupational Therapy	☐	Neurologist	☐
Physical Therapy	☐	Orthopedist	☐
Emergency Room Care	☐	X-Rays	☐
CT Scan	☐		

Other: ____________________

Check ALL conditions you have had below if applicable:

Shortness of Breath/Chest Pain	☐	Arthritis/Swollen Joints	☐
Coronary Heart Disease or Angina	☐	Osteoporosis	☐
Pacemaker or defibrillator	☐	Sleeping Problems/Difficulties	☐
High Blood Pressure	☐	Emotional/Psychological Problems	☐
Heart Attack	☐	Vision or Hearing Difficulties	☐
Stroke/TIA	☐	Numbness or Tingling	☐
Blood Clot/Emboli	☐	Dizziness or Fainting	☐
Epilepsy/Seizures	☐	Weakness	☐
Thyroid Trouble/Goiter	☐	Weight Loss/Energy Loss	☐
Anemia	☐	Do you smoke?	☐
Infectious Disease	☐	Are you pregnant? # weeks _____	☐
Diabetes	☐	Had a Major Surgery	☐
Cancer or Chemotherapy/Radiation	☐	Allergies	☐

Please provide your Medications List: ____________________

Consent and Statement of Financial Responsibility

Patient Name: ____________________________ **Date:** ______________________

Med Rec #/Account # ___________________________________ *(Internal use only)*

I hereby consent to the use and disclosure of my health information for treatment provided to me by this physical therapy practice, payment for services provided by the provider or other health care providers and the operations of this physical therapy practice and others under certain circumstances. I understand that a more detailed explanation of the ways of this physical therapy practice may use and disclose my health information is contained in the Notice of Privacy Practices of the Provider, a copy of which has been provided to me.

PATIENT CODE OF CONDUCT

It is our goal to provide the highest quality of care in a safe environment. In our efforts to achieve this goal, we require all patients and visitors to refrain from any behavior that may pose a threat to the rights or safety of other patients and employees. Our patients agree to refrain from the following actions: (1) Bringing firearms or other weapons into the clinic; (2) Inappropriate behavior involving alcohol/substance use at time of treatment; (3) Attempting to intimidate or harass in any manner therapists, staff, or fellow patients; (4) Inappropriately touching therapists, staff, or fellow patients; (5) Racial or cultural slurs or other derogatory remarks associated with, but not limited to, race, language or sexuality; (6) Making verbal threats to harm another individual or destroy property through any medium of communication; and (7) Physical assault or inflicting bodily harm, Violators of the abovementioned actions may be asked to leave the facility and/or be discharged from the clinic. My signature below indicates that I will support the clinic in its efforts to provide me with quality care in a safe environment and that I understand and accept the terms of the Patient Code of Conduct.

CONSENT FOR TREATMENT

I hereby consent to physical or occupational therapy services deemed medically necessary by my therapist and other health care professionals involved in my care. I understand that my physical therapy program may include remote therapeutic monitoring (RTM). RTM services include telephone or video communications from a clinician to review my progress between in-clinic visits. This communication will allow my therapy team to monitor my progress and adjust my home exercise program as necessary to achieve my rehabilitation goals. I will receive complimentary access to the MedBridgeGo© software as well as education to use the app throughout my course of care.

CANCELLATION AND NO SHOW POLICY

Patients are expected to keep all scheduled appointments to maximize the benefits of their treatment plan. If a patient is unable to make a scheduled appointment, the patient is

expected to give 24 hours advance notice or may be charged a cancellation fee of $60. Two (2) consecutive appointment no-shows may result in discontinuation of the current appointment schedule for the therapy involved. A pattern of frequent absences (cancellation and/or no-shows) will be considered problematic and result in discontinuation of services. Planned absences from scheduled therapy will not be considered cancellations or no-shows. If a patient provides notice of a planned absence, their on-going schedule may be placed on “hold” for up to two (2) weeks. A renewed prescription and appointment schedule may need to be arranged depending on the length of time which has passed.

TELEPHONE CONSUMER PROTECTION ACT NOTICE

In order to service my account or to collect any amounts I may owe, you may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in a charge to me. You may also contact me by sending text messages or e-mails, using an e-mail address I provide to use. Methods of contact may include using pre-recorded/ artificial voice messages and/or use of an automatic dialing device, as applicable.

HIPPA PATIENT PRIVACY NOTICE

Consent and Authorization

The undersigned patient hereby consents to the evaluation, treatment, procedures and services to be performed by BODYSET INC (“Provider”).

GEORGIA LAW: PLEASE COMPLETE AND RETURN THIS FORM IN ORDER FOR US TO FILE THIS CLAIM WITH YOUR AUTO INSURANCE.

AUTHORIZATION FOR RELEASE OF INFORMATION, INFORMED CONSENT AND APPOINTMENT OF PATIENT REPRESENTATIVE

I HEREBY AUTHORIZE THE RELEASE of information from my medical records for the purpose of financial reimbursement for services rendered. I request that payment be made directory to THE ABOVE AGENCY. I certify that the information given by me is correct, and that this case is subject to Peer Review Organization quality review in the event of a written complaint.

I CONSENT TO RELEASE OF MY MEDICAL RECORDS to be reviewed by authorized representatives of Medicare, Medicaid, Blue Cross/Blue Shield and/or my private insurance carrier(s). In addition, I authorize the records to be reviewed for audits within the agency.

I CONSENT TO THE RELEASE OF MEDICAL INFORMATION to physicians, hospitals, extended is facilities or community resources as needed.

I CONSENT TO THE RELEASE OF PATIENT NAME to physicians, hospitals, and other source(s) that has referred me to THE ABOVE AGENCY (Thank you cards).

I AUTHORIZE THE STAFF OF THE ABOVE AGENCY to carry out all procedures as ordered by my physician.

AUTHORIZATION OF PATIENT REPRESENTATIVE TO MEDICARE: In the event that my claim for benefit payment is denied, I appoint THE ABOVE AGENCY to act as my representative in connection with my claim under Title XVIII (Medicare coverage). I authorize this agency to make or give any request, to present evidence, obtain information and to receive notice in connection with my claim in asserted right wholly in my stead, with no fee incurred. I understand that Medicare will pay 80% of these charges after the deductible and co-insurance (if applicable). I will pay 20% co-insurance and deductible.

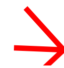
WORKER'S COMPENSATION, AUTO & OTHER LIABILITY INSURANCE CLAIMS AUTHORIZATION

Bodyset Inc assumes your right or the right of your beneficiaries, to recover money from another person, insurance company or organization. You grant us your right to recover services tendered to you, together with interest and cost, from the person, insurance company or organization. You grant us a lien on all money that you or your beneficiaries recover through settlement, verdict or judgment. You agree to inform us when you hire an attorney to represent you and to inform your attorney of our right under this certificate. You are required to do whatever is necessary to help us enforce our right of recovery, including but not limited to, executing, delivering instruments and paper necessary to secure those rights.

I hereby authorize Physical Therapy Bodyset Inc to bill my insurance company and receive the payment directly from them. I agree to pay co-pays & deductibles issued by my insurance. For non-covered services, I agree to pay charges upon receipt, unless arrangements have been agreed to by THE ABOVE AGENCY and patient/guardian.

CONSENT FOR CARE

I (or my legal guardian or parents) authorize Bodyset Inc to provide Medical Care reasonable to today's standards. I have received and reviewed this document in its entirety. I understand the rights and protections offered to me by the HIPAA provisions. Lastly, I understand that this document and the protections it offers are for my benefits.



Patient/Legal Guardian NAME | **Date**

Patient/Legal Guardian SIGNATURE | **Date**