PATIENT INFORMATION FORM

PRIVATE INSURANCE

PATIENT'S NAME____

ADDRESS____

CITY_________________________STATE__________ZIP____________________

HOME#_________________________SPOUSE______________________________

CELL#_________________________DATE OF BIRTH_________________________

WORK#_________________________

NORTHERN ADDRESS____

NORTHERN PHONE#____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

____

WHOM MAY WE CONTACT IN CASE OF AN EMERGENCY?

____
(NAME) (PHONE#)

WILL BE PAYING MY CO-PAYMENT AT THE END OF EACH WEEK BY:

CHECK_____ CREDIT CARD_____ CASH_____

A 10% DISCOUNT WILL BE GIVEN FOR CASH PAYMENTS

By signing below, I give Boynton Sport and Back Physical Therapy permission to give me necessary medical treatment.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for all professional services rendered.

I authorize / do not authorize (circle one) the release of identifiable personal information, except when such release is required by law.

SIGNATURE ______________________________ DATE ________________

(OVER PLEASE)

FINANCIAL ARRANGEMENTS
AND YOUR MEDICAL INSURANCE

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

We are happy to file your insurance claim for you. If you wish us to do so, please read this carefully and sign the bottom of this sheet.

Co-payment and deductible payments are due the end of every week of treatment. We accept cash, checks, and credit cards.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize however, that your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.

Our fees are considered to be reasonable and customary and are covered up to the maximum allowance determined by your insurance.

We must emphasize that as Physical Therapists, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibilities from the date of services are rendered.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to speak to us. We are here to help you.

I have read and understand the above information.

SIGNATURE ___________________________________ *DATE*______________________

FUNCTIONAL ASSESSMENT

Instructions: Please place "X" in the column which describes your level of difficulty.	Able to do without any difficulty	Able to do with little difficulty	Able to do with moderate difficulty	Able to do with much difficulty	Unable to do	Not applicable
Lying Flat						
Rolling Over						
Moving – Lying to Sitting						
Sitting						
Squatting						
Bending/Stooping						
Balancing						
Kneeling						
Walking – Short Distance						
Walking – Long Distance						
Walking – Outdoors						
Climbing Stairs						
Bathing						
Dressing/Hook Bra						
Household Chores						
Cooking						
Pulling						
Reaching						
Grasping						
Lifting						
Carrying						

Thinking about all of the activities you would like to do, please mark an "X" at the point on the line that best describes your overall level of difficulty with these activities today.

[--]

No difficulty Extreme difficulty

At present time would you say that your health is: Excellent Very Good Fair Poor (Circle One)

	YES	NO
Diabetes		
Chest Pain/Angina		
High Blood Pressure		
Heart Disease		
Heart Attack		
Heart Palpitations		
Pacemaker		
Headaches		
Kidney Problems		
Stroke		
Cancer		
Abnormalities		
Urine Leakage		
Asthma/Breathing Difficulties		
Liver/Breathing Difficulties		
Smoking		
Falls in the past year		

	YES	NO
Vertigo		
Allergies to Heat		
Allergies/Poor Tolerance to Cold		
Other Allergies		
Hernia		
Seizures		
Metal Implants		
Dizziness/Fainting		
Recent Fractures		
Surgeries		
Skin Abnormalities		
Sexual Dysfunction		
Nausea/Vomiting		
Ringing in your ears		
Rheumatoid Arthritis		
Special Diet Guidelines		
Hypoglycemia		

Patient Name:_______________________________ Date____________________

JANUARY 2014

We are now required to document all of the medications you are taking, including prescriptions, over-the-counter, herbals, vitamins and minerals/dietary supplements.

If you have a list, please give it to Tara and she will make a copy. If not, please fill out the following.

Medication Name	**Dosage**	**Frequency**

1. ______________________________

2. ______________________________

3. ______________________________

4. ______________________________

5. ______________________________

6. ______________________________

7. ______________________________

8. ______________________________

9. ______________________________

10. ______________________________

11. ______________________________

HIPPA

PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand Boynton Sport and Back Physical Therapy Provider's Notice of Information Practices. I understand that Boynton Sport and Back Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that Boynton Sport and Back Physical Therapy will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes of health information.

____

Patient Name (print)

____________________________________ ______________________________.

Signature Date