BeMORE PHYSICAL THERAPY

PATIENT INFORMATION FORM

Name: _____ DOB: _____ /____ /_____
Last Middle First

SS# _____-_____-_____ Gender: _____ Age: _____

Address: _____
Street City State Zip

Email: _____

Phone Number: _____ Additional Phone Number: _____

May we send you text messages for your appointment reminders to the number listed above? ④ Yes ④ No

Occupation: _____ Employer: _____

Emergency Contact/relationship: _____ Phone #: _____

Primary Complaint/ Reason for attending PT: _____

Date of injury or start date of problem: _____ Date of Surgery: _____

ACCIDENT/INJURY INFORMATION

Date of Accident: _____/_____/_____ Type of Accident: ☐Auto ☐Slip and Fall ☐On the Job

Body Parts Injured: _____

Referring Doctor: _____ _____
Full Name Phone Number

Attorney: _____ _____
Full Name Phone Number

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MEDICAL HISTORY

Name: _____ DOB: _____ /____ /_____ Height: _____ Weight: _____

Please check all that apply:

☐ High Blood Pressure	☐ Heart Disease	☐ Blood Clot/DVT/PE
☐ Arthritis/Fibromyalgia	☐ Shortness of Breath	☐ Diabetes
☐ Stroke/TIA	☐ Chest Pain	☐ Pins/Metal Implants
☐ Cancer	☐ Heart Attack/Surgery	☐ Joint Replacement
☐ Infectious Disease	☐ Osteoporosis	☐ Epilepsy/Seizures
☐ Depression/Anxiety	☐ Congestive Heart Failure	☐ Pacemaker

☐ Do you have a Pacemaker:_____

☐ Allergies: _____

☐ Other: _____

Medications:_____

Have you been hospitalized for the current condition? _____ If so, when? _____

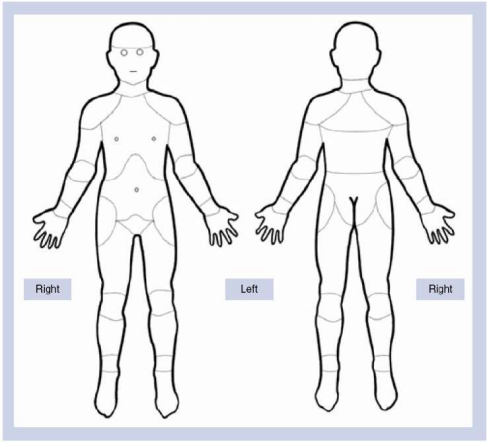
Do you smoke? Y N Do you use illegal drugs? Y N How many drinks do you have/week? _____

Do you have steps to enter/exit your home? _____ If so, how many? _____

Lifestyle?: Sedentary Moderate Active

What are your physical therapy goals? _____

Please circle the area(s) where you are experiencing pain:



Circle Pain Level: At its Worst: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

No Pain Worst Pain

At its Best: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

No Pain Worst Pain

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize the release of my medical records to BeMore Physical Therapy, LLC to be used for continuing medical care. I reserve the right to revoke this authorization in writing at any time. Furthermore, I understand that this Protected Health information may be re-disclosed by the recipient and thus, is no longer protected under privacy rules.

By signing this authorization, I understand that medical records released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.

Patient Name: _____

Date of Birth: _____

Patient's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Please fax records to:

BeMore Physical Therapy, LLC
Fax number (443)440-6269

BeMORE PHYSICAL THERAPY

Patient Name:_____ **Date:**_____

CONSENT TO TREATMENT: I consent to rehabilitation and related services at BeMore, LLC. In doing so, I understand, acknowledge and affirm that such rehab and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature. **Initials:** _____

CANCELLATION POLICY: If I cancel or do not show for an appointment within 24 hours of the appointment date, I understand that I may be charged a $40 fee. **Initials:** _____

TREATMENT OF MINORS: I, as parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premise during any such treatment, and waive any claim I may have resulting from failure to do so. **Initials:** _____

LIABILITY: BeMore, LLC is not responsible for loss or damage to personal valuables. **Initials:** _____

WAIVER AND RELEASE: I hereby release, discharge, and acquit BeMore, LLC, its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive, or allow emergency and or medical services, including but not limited to ambulance, Emergency Medical Technician, physician, or urgent care services. **Initials:** _____

AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to BeMore, LLC and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. **Initials:** _____

NOTICE OF PRIVACY: I acknowledge receipt of the Notice of Privacy Practices, Patient's Rights, Consent to Marketing Materials and Testimonial Release, and HIPAA Authorization for Disclosure of Protected Health Information.

Initials:

_____

BENEFIT INFORMATION: Upon your first visit to the office, you will sign a benefits information sheet based on the most current information provided to us. Per the insurance disclaimer, this information is not a guarantee of payment and subject to all applicable policy restrictions. Should this information be misquoted, we cannot be held liable. If you wish to call your carrier to verify your benefits our staff can provide you with assistance. **Initials:** _____

EXCEEDING AUTHORIZATION: Certain carriers have restriction and limitations on Physical Therapy services. Therefore, it is the patient's responsibility to ensure these restrictions are not exceeded. Should these restrictions be exceeded patients will be granted the self-pay courtesy rate, per our current policy. **Initials:** _____

I certify that all the above information provided is true and correct. I hereby, authorize and instruct my insurance carrier to pay BEMore, LLC directly for any physical therapy services performed. Additionally, I understand that I am financially responsible for payment of all copays, deductibles and balances not covered by my insurance carrier, provided my specific plan does normally pay for the services and/or products rendered to me by the medical providers at this facility. In the event an outstanding balance is referred to an attorney for collection, I will be responsible for all costs of collection to include but not limited to litigation expenses, court costs, service of process fees and attorney's fees not to exceed twenty (20%) percent of the outstanding balance. I also waive the right to claim statue of limitations as a defense in any collection action and that any outstanding balance may accrue interest at a rate of eighteen (18%) percent per annum.

Patient/Guardian Signature_____ Initials: _____ Date_____