biomechanix
PHYSICAL THERAPY

NEW PATIENT INFORMATION FORM

Patient Name: _____ Date: _____

(First Middle Last)

Date of Birth: _____ Social Security #: _____ Gender: M / F / Prefer Not to Answer

Address: _____

City: _____ State: _____ Zip: _____

Home Phone#: _____ Cell#: _____ Email: _____

Employer: _____ Work Phone Number: _____

Emergency Contact: _____ Phone #: _____

Referring Physician: _____

Date of Injury/Illness: _____ Primary Complaint: _____

Was this a result of a motor vehicle accident? YES / NO **Work-related injury?** YES / NO

How did you hear about us: _____

Primary Insurance Company: _____

ID#: _____ Policyholder: _____ Date of Birth: _____

Secondary Insurance Company: _____

ID#: _____ Policyholder: _____ Date of Birth: _____

Worker's Compensation Claims:

Adjuster Name/Company: _____ Phone #: _____

Case Manager Name: _____ Phone#: _____

Claim #: _____

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PHYSICAL THERAPY

BILLING POLICIES, ASSIGNMENT OF BENEFITS & PATIENT INFORMED CONSENT FORM

BILLING POLICIES & ASSIGNMENT OF BENEFITS

Biomechanix Physical Therapy will bill your insurance carrier for our services. Annual deductibles, co-pays and co-insurance are due at the time of service.

Any claims or services denied by insurance become the responsibility of the patient and are due within 30 days of receipt of the statement.

Some insurance carriers require a physician's order for physical therapy services to be reimbursed. It is the responsibility of the patient to obtain this from their physician.

If you have received **in-home care**, your insurance requires that you be discharged from in-home care **prior** to starting outpatient physical therapy. It is the responsibility of the patient to confirm this with their in-home provider. If your insurance denies claims for this reason, you may be responsible for payment.

The Biomechanix billing staff will be happy to assist you with any questions or concerns you may have regarding financial matters.

I have read and agree to comply with the billing policies of Biomechanix Physical Therapy. I authorize Biomechanix Physical Therapy to submit claims to my insurance carrier on my behalf and assign Biomechanix the right to receive payments. If payment is made directly to me in error, I agree to reimburse Biomechanix Physical Therapy for these amounts within 5 days of receipt of payment. I understand Biomechanix cannot guarantee that information received from my insurance company is accurate.

INFORMED CONSENT

I have read and fully understand the Biomechanix Physical Therapy Notice of Information Practices. I understand that Biomechanix Physical Therapy may utilize or disclose my health information in order to carry out treatment, to obtain payment and to evaluate the quality of care. I understand that I may request a restriction of the dissemination of my health information in the above cases but Biomechanix Physical Therapy does not have to legally honor these requests.

I hereby consent to the use and disclosure of my health information for purposes as noted in the Biomechanix Physical Therapy Notice of Information of Practices. I understand that I have the right to revoke this consent in writing at any time.

Patient Name (print): _____

Patient/Guardian Signature: _____

Date: _____

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PHYSICAL THERAPY

CONSENT FOR TREATMENT

Physical therapy is a patient care service provided in response to a wide variety of medical care needs of outpatients of all ages, regardless of gender, color, race, creed, national origin or disability.

The purpose of physical therapy is:

- To treat disease, injury and disability by evaluation, examination, testing and use of rehabilitative procedures, manipulations, massage, exercise and physical agents including but not limited to mechanical devices, heat, cold, air, light, water, electricity and sound in the aide of diagnosis and/or treatment.
- To obtain for the physician, information needed in diagnosis and evaluation of patients.
- To prevent or minimize residual physical and mental disability.
- To accelerate convalescence and reduce the length of functional recovery time.

All procedures will be thoroughly explained to you before they are performed.

There are certain inherent risks with physical therapy treatment because you will be asked to exert effort and perform activities with increasing degrees of difficulty. This could cause an increase in your current level of pain or discomfort or an aggravation to your existing condition. There is also a possibility that you could experience a new injury, but this risk is small. You will be able to control any procedure by stopping if you feel any increase in pain or discomfort. You will never be forced to perform any procedure that you do not wish to perform.

For personal safety, please do not use any equipment without a staff member present.

I hereby grant my consent for evaluation and treatment to be provided by Biomechanix Physical Therapy.

Patient Name (print): _____

Patient/Guardian Signature: _____

Date: _____

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PHYSICAL THERAPY

PHOTO RELEASE AND ELECTRONIC DEVICE

PHOTO RELEASE

I, (print patient name) _____hereby give permission to Biomechanix Physical Therapy to use any still photos of myself performing therapeutic and/or strength and conditioning exercises for the purpose of creating *my* personal home exercise program(s), and for updating my doctor on my progress.

I also understand that in no way will said photos be used for purposes other than those listed above.

Patient Name (print): _____

Patient/Guardian Signature: _____ Date: _____

ELECTRONIC DEVICE POLICY

As a courtesy to our front office staff and other patients, please refrain from loud cell phone conversations or electronic device usage while in the lobby. This will ensure that we are able to properly serve our patients. Use of cameras in the treatment and gym area is prohibited unless you have your therapist's explicit consent to do so.
Thank you for your cooperation. Our staff will offer friendly reminders along the way.

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PHYSICAL THERAPY

ATTENDANCE POLICY AND CANCELLATION OF APPOINTMENTS

We, as the provider of rehabilitation therapy, strive to provide the highest quality of care while attempting to accommodate each patient's schedule. Therefore, we provide each patient a reserved time slot with a specific therapist in order to minimize wait time and assure continuity of treatment. Consistent attendance and adherence to the planned treatment regimen is paramount to your care and recovery.
While we are sensitive to the fact that an emergency may occur, cancellations, tardiness and absentees reduce our ability to accommodate the scheduling needs of our patients. As such, we request your full cooperation with the following company policy:

- If a patient is more than 15 minutes late for an appointment and fails to notify the clinic of the tardiness, treatment may be cancelled and a **cancellation fee** may be charged for missing the appointment.
- A scheduled appointment must be cancelled at least 24 hours in advance or a **cancellation fee** may be charged for that appointment.
- Failure to show up for a scheduled appointment without providing the clinic advanced notification of your absence may result in a **cancellation fee** being charged for that appointment. Furthermore, 2 consecutive absences without advanced notification may result in the cancellation of all your remaining scheduled appointments; as such failures may negatively impact your treatment plan.
- Patients that cancel a scheduled appointment less than 24 hours in advance, are late to an appointment or absent from a scheduled appointment will be charged a $25 **cancellation fee**. The patient is responsible for the **cancellation fee**, not the insurance company or third-party payor. Please note that a **cancellation fee** will not be charged if the missed appointment is rescheduled within a week of the tardiness, absence or late cancellation and another appointment was not previously scheduled
- Repeated failure to comply with this policy will result in your appointments being scheduled based on availability, which may require you to call for an appointment on the day you would like to receive therapy.

I read and understand the above attendance policy.

Patient/Guardian Signature: _____ Date: _____

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PHYSICAL THERAPY

Patient Name: **Date:**

Are you currently taking any medications? Yes___ No___ **Please List:** _____
Are you currently receiving home health care? Yes___ No___ (use back for additional space)

Condition	Yes	No	Date	Condition	Yes	No	Date
Asthma	___	___	_____	Fracture/Broken Bones	___	___	_____
Diabetes	___	___	_____	Neuromuscular	___	___	_____
High Blood Pressure	___	___	_____	Dizziness/Blackouts	___	___	_____
Heart Problems	___	___	_____	Headaches/Migraine	___	___	_____
Lung Problems	___	___	_____	Blood Clots/ Vascular	___	___	_____
Cancer	___	___	_____	Bladder/Bowel Disorder	___	___	_____
Seizures	___	___	_____	Pregnancies # _____	Dates: _____		
Arthritis	___	___	_____	Other: _____			
Stroke/CVA	___	___	_____				

Surgical	Yes	No	Date	Please Describe
Orthopedic Surgery	___	___	_____	_____
Joint Replacements	___	___	_____	_____
Spinal Surgery	___	___	_____	_____
Heart Surgery	___	___	_____	_____
Fracture Reductions	___	___	_____	_____
Joint Manipulations	___	___	_____	_____
Other Surgeries	___	___	_____	_____

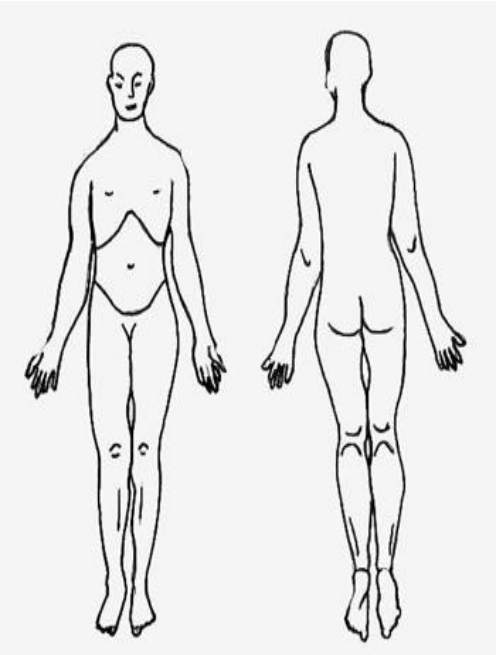
Current Limitations/Restrictions _____

Diagnostics	Yes	No	Date	Results
X-Rays	___	___	_____	_____
CT Scans	___	___	_____	_____
MRI	___	___	_____	_____
EMG Nerve Studies	___	___	_____	_____
Injections	___	___	_____	_____

Pain/Symptoms

1. Please rate your current pain level by marking a number on the scale:
   0 _____ 10
   (No Pain) (ER Visit)

2. On the **BODY DIAGRAM►** please describe your symptoms using the following symbols:
(X) Sharp (=) Numb/Tingling (#) Ache (B) Burning



Patient/Guardian Signature: _____