"Movement for Life"

Brunswick Physical Therapy, PLLC.
Medical History

Patient Name:			**Date:**
Prescription Medications			
Name of Medication	**Dosage Ex (mg, cc)**	**Frequency Ex (2 x Daily)**	**More Info if needed**
Surgery Dates (Past & Present)	**Body Part**	**Allergies**	**Reaction**

Place an "X" if you have experienced or been told that you have any of the following:

Asthma		Kidney Disease		Fainting	
Emphysema		Hepatitis/Jaundice		Migraine/Headaches	
Chest Pain		Bowel/Bladder Problems		Osteoporosis	
Heart Disease		Blood Disorder		Cancer	
Stroke		Pregnancy		Visual Loss	
Dizziness		Shortness of Breath		Hearing Loss	
Epilepsy/Seizures		High Blood Pressure		Chemical Dependency	
Arthritis		Blood Clot		Depression	
Diabetes		Head Injury/Concussion		Anxiety	
Fibromyalgia		Any Neurological Diseases		Thyroid Problems	
AIDS/HIV		Other:			

Place an "X" for any tests you have had for the condition you are being seen for today:

X-Ray		Ct Scan		MRI	
Ultrasound		Bone Scan		Blood Test	
EMG		NCV		Other:	

Please list any other information you feel we should know

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Medical History (PART II)

Patient Name: _____ **Date:** _____

How did you hear about us? (Please Circle one):
Returning Patient / Friend / Family / Doctor / Online (Website, Facebook) / Workshop
Other:_____

Doctor Follow Up Date: _____

- Briefly describe your symptoms :
  _____
  _____
  _____
- When did your symptoms start? _____
- How did your symptoms start?
  _____
  _____
  _____
- What makes your symptoms better? (circle all that apply): Sitting Standing Bending

  Lying Down Walking Other: _____
- What makes your symptoms worse? (circle all that apply): Sitting Standing Bending

  Reaching Lifting Lying Down Walking Other: _____
- Is your pain …. Constant / Intermittent / Not applicable

How would you rate your pain?

At Best 0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Pain

At worst 0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Pain

Today 0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Pain

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HIPAA

Consent to Use and Disclosure of Protected Health Information

Date: _____

Name: _____ DOB: _____/_____/_____

Medical Release of Information: I hereby authorize Brunswick Physical Therapy, PLLC. and its representatives to furnish medical information, including e-mail of faxed copies of my records to my referring physician(s) and to my insurance company, if requested. As a patient or legal guardian of a patient, I understand that payment for today's service and any future service is ultimately my responsibility. I also authorize a representative of Brunswick Physical Therapy, PLLC. to speak with my insurance carrier on my behalf if required. **I understand that this office bills insurance as a courtesy and that payment of the charges for these services is my responsibility.** A photographic copy of this authorization shall be as valid as the original.

I consent to receive calls, texts, emails, and postcards from Brunswick Physical Therapy, PLLC. for purposes of appointment reminders. I am aware that I can review the Notice of Privacy Practices before signing this consent (available at the front desk). I hereby authorize Brunswick Physical Therapy, PLLC. to disclose the information about myself (or another person for whom I have authority to sign) that is protected under federal law for treatment, payment, and healthcare operations.

I also authorize Brunswick Physical Therapy, PLLC. to communicate with the following individual(s) about my condition or treatment. In accordance with federal laws, **I understand that medical information may be withheld from individuals (including family members) unless I list them below.**

Name	**Relationship to Patient**
_____	_____
_____	_____
_____	_____

Emergency Contact (Name and Phone#):_____

X _____

Signature of Patient, Parent, or Legal Guardian

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Brunswick Physical Therapy, PLLC
Patient Payment & Attendance Policy

Payments

All co-pays are due at time of treatment.

Payment may be made by check or cash. (Checks can be made out to BPT). We also accept credit/debit card payments as well as Flex Spending Account (FSA) or Health Savings Account (HSA) cards.

A **$20 service fee** will be charged for checks returned for any reason.

Any bills submitted to the patient are payable upon receipt.

Attendance

Your regular attendance is critical to your success. If you find it necessary to cancel an appointment for any reason, we require 24 hours' notice. **You may be charged a $30 fee for a late cancellation**.

No shows will be charged a $30 fee which is not covered under your insurance benefit.

(2) No shows will consist in an immediate discharge from physical therapy.
(3) Cancelations in a row will consist in an immediate discharge from physical therapy.

***BPT reserves the right to discharge anyone who demonstrates poor attendance.**

I understand and agree to the office procedures outlined above.

X _____ X _____

Patient Signature/Responsible Party **Date**

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Brunswick Physical Therapy, PLLC
Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with

_____ and assign directly to **Brunswick Physical**
(Patients Primary Insurance Carrier)

Therapy, PLLC. all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for ask charges whether or not paid by insurance. I hereby authorize the Physical Therapist/Brunswick Physical Therapy, PLLC. the use of this signature on all insurance

submissions.

X _____
Patients Printed Name

X _____ X _____
Signature of Patient/Responsible Party Date