**Body In Balance Physical Therapy Patient Information Form**

Patient Name: \_\_\_\_\_ \_\_\_\_\_\_\_\_\_ Sex: □ M □ F

Date of Birth: \_ Age: \_\_\_\_\_ Patient Social Security #:

Home Phone: \_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_(for therapist communication)

Mailing Address: City/State: Zip Code:

Driver’s License #: \_\_ State: \_\_\_\_\_\_\_\_ Exp. Date:

Full Time Student: Yes No Name of School: \_\_\_\_\_\_\_

Emergency contact: \_\_\_\_\_\_ Phone:

Who is responsible for patient remainder balances? \_\_\_\_\_\_\_\_\_\_\_\_

Name of referring/primary physician: \_\_\_\_\_\_\_

Did you sustain an injury at work? □Yes □No

Are you covered under an employer or union policy? □Yes □No

Are your injuries accident related? □Yes □No If Yes what type: □Auto □Work □Other

Is your spouse or other family member employed? □Yes □No

Are you currently employed? □Yes □No

Do you have a secondary insurance policy? □Yes □No

Have you ever served in the military? □Yes □No

Are you covered under any other health care plan? □Yes □No

Are you currently receiving Home Healthcare? □Yes □No

**COVID-19 Screening:**

In the past 14 days:

Do you or anyone in your household have any of the following?

□ Fever above 100 degrees

□ Shortness of breath (not severe)

□ Cough

□ Chills

□ Repeated shaking with chills

□ Muscle pain

□ Headache

□ Sore throat

□ New loss of taste or smell

□ None

Have you or anyone in your household traveled outside of Alaska? □Yes □No

Have you had close contact with a laboratory-confirmed COVID-19 patient?? □Yes □No

**If you marked Yes to any questions, please talk to the staff before continuing.**

I agree if I or any household member has one or more symptom(s) that may be related to COVID-19 or has traveled outside of Alaska that I will call before my appointment to reschedule and stay home and take care. **INITIAL \_\_\_\_\_**

**Medical Insurance information:**

□ I do not have any medical coverage at this time.

**ONLY Injury/Accident Insurance**

Related to: □Auto □Home □Sports □Work- Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Carrier Name: \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_

Claim Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Injury: \_\_\_\_\_\_\_\_\_\_

Name of Adjuster: \_\_\_\_\_\_\_ Adjuster Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Medical Insurance**

Insurance Carrier Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insured Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_ Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Identification Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Identification card present upon encounter: □Yes □No

**Secondary Medical Insurance**

Insurance Carrier Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insured Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_ Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Identification Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Identification card present upon encounter: □Yes □No

**Tertiary Medical Insurance**

Insurance Carrier Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insured Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_ Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Identification Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Identification card present upon encounter: □Yes □No

I authorize treatment by Body In Balance Physical Therapy. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

**Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Body In Balance Physical Therapy Notice of Privacy Practices**

Our commitment at **Body In Balance Physical Therapy** is to serve our patients with professionalism and care, being sure always to protect the privacy and security of all Protected Health Information.

**OUR LEGAL DUTY**

We at **Body In Balance Physical Therapy** are committed to obeying all Federal, State, and local laws and regulations regarding Privacy Practices. If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided for by law.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

Body In Balance Physical Therapy uses your personal and health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and assessing the quality of care we are proud to provide. We use your personal information to contact you to arrange an appointment with us and to properly bill your insurance carrier for the services we provide you. Body In Balance Physical Therapy will always obtain your written permission and authorization before disclosing your personal health information. If you provide us with written authorization to release your information for any other reason, you may later revoke that authorization to cease future disclosures at any time.

**PATIENT’S INDIVIDUAL RIGHTS**

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct inaccurate or incomplete information in your records. You also have the right to request a list of instances where we disclosed your personal health information for reasons other than for treatment, payment, or administrative purposes except when specifically authorized by you, when required by law, or in an emergency. Body In Balance Physical Therapy will consider all such request on a case-by-case basis. The company is not legally required to accept requests.

If you have any questions or comments regarding your Protected Health Information, feel free to contact our manager at (907) 746-0768.

**I have read and understand the above Notice of Privacy Practices.**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Body In Balance Physical Therapy Financial Agreement**

We, the staff of **Body In Balance Physical Therapy** thank you for choosing us as your medical provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family. We believe your understanding of our patients’ financial responsibility is vital to that provider-patient relationship and our goal is not only to inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies, or responsibilities please feel free to contact our office manager at (907) 746-0722.

Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in advance by our staff.

We make payment as convenient as possible by accepting (cash, money order, MasterCard, Visa, Discover, American Express and in-state checks). A $35.00 service fee will be charged for all returned checks.

**Insurance**

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization, and referral information and to notify our office of any information changes when they occur. Even a preauthorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information. It is the patient’s responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obliged to collect copayments, coinsurance, and deductibles, as outlined by your insurance carrier.

Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of-network fees. If we are not contracted with your carrier, we will not negotiate reduced fees with your carrier.

**Missed Appointments**

We require notice of cancellations 24 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advance: a missed appointment fee will apply. These fees are typically $25.00 but not to exceed one-half of the cost of your scheduled appointment. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients.

**Medical Records Fees**

Patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines, and exceptions to ensure compliance to patient rights. However, providers also have the right to compensation for records and our fees are a reasonable cost-based fee for copies including the copying, supplies, labor, and postage of the files, and or summaries.

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

**Timeliness of Appointments**

We try to see everyone in a timely manner but if we are taking too long, please let our receptionist know so we can best serve your needs and reschedule you if necessary.

**I have read and understand the above financial policy. I agree to assign insurance benefits to whenever applicable.**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Body In Balance Physical Therapy Assignment of Benefits Form**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand that services rendered to me by Body In Balance Physical Therapy are my financial responsibility and that the provider will bill my insurance company below, as a courtesy.

Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID#: \_\_\_\_ Group#: \_\_\_\_\_

I authorize my insurance company to pay my benefits directly to Body In Balance Physical Therapy, 642 S Alaska St. #209, Palmer, AK 99645 and I understand that I will be fully responsible for any outstanding balance on my account. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to Body In Balance Physical Therapy within 48 hours. I agree that if I fail to send the payment to Body In Balance Physical Therapy they will be forced to proceed with the collections process. In the event the patient receives any check, draft, or other payment subject to this agreement, I will immediately deliver said check, draft, or payment to provider. Any violations of this agreement will, at provider’s election, terminate patient charge privileges with provider and make any patient balance immediately due.

I authorize Body In Balance Physical Therapy to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials. A photocopy of this Assignment shall be considered as effective and valid as the original.

**Signature of Patient or Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated**

**Body In Balance PT   
General Patient Information**

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question, leave it blank and your physical therapist will assist you. Thank you.

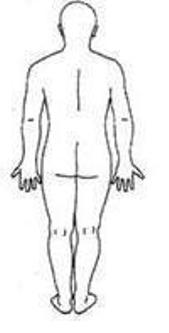
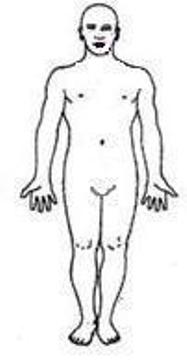
1. What is your main complaint or injury?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. When did this episode begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. How did your problem start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Did you have surgery for this injury? \_\_\_\_YES \_\_\_\_NO Date of Surgery:\_\_\_\_\_\_\_\_\_\_\_
5. Do you have a history of similar episodes/complaints? \_\_\_\_YES \_\_\_\_NO
6. What would you rate your baseline level of function prior to current injury status?

0% 25% 50% 75% 100%

extremely limited semi-limited not limited

1. List three activities that you are unable to do because of your current complaint or injury?
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Please rate your pain at worst ☹ current 😐 and best ☺ below.

0 1 2 3 4 5 6 7 8 9 10  
 no pain mild discomfort moderate discomfort extreme discomfort

1. Please indicate the painful areas by shading the model:

Right Left Left Right

side side side side

1. What positions/activities make your pain worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. What positions/activities lessen your pain?­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Does your current complaint affect your sleep? \_\_\_YES \_\_\_NO
4. Have you had an x ray, MRI or CT scan for your current injury? \_\_\_YES \_\_\_NO
5. Current Height \_\_\_\_ ft \_\_\_\_in Weight \_\_\_\_\_\_ lbs
6. Do you have children? \_\_\_YES \_\_\_NOHow many? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Are you currently working outside of the home? \_\_\_YES \_\_\_NO
8. Are you receiving treatment for any other medical condition? \_\_\_YES \_\_\_NO

If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you been treated for this condition by any of the following?

\_\_ Medical Doctor \_\_Osteopath \_\_Dentist\_\_ Psychiatrist \_\_Physical Therapist \_\_Chiropractor \_\_Occupational Therapist \_\_Personal Trainer Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you **EVER** been diagnosed with any of the following conditions?

\_\_\_YES \_\_\_NO Cancer \_\_\_YES \_\_\_NO Heart problems

\_\_\_YES \_\_\_NO High Blood pressure \_\_\_YES \_\_\_NO Thyroid problems

\_\_\_YES \_\_\_NO Circulatory problems \_\_\_YES \_\_\_NO Diabetes

\_\_\_YES \_\_\_NO Asthma \_\_\_YES \_\_\_NO Multiple Sclerosis

\_\_\_YES \_\_\_NO Stomach ulcers \_\_\_YES \_\_\_NO Urinary Incontinence

\_\_\_YES \_\_\_NO Chemical Dependency \_\_\_YES \_\_\_NO Other arthritic conditions

\_\_\_YES \_\_\_NO Depression \_\_\_YES \_\_\_NO Hepatitis

\_\_\_YES \_\_\_NO Tuberculosis \_\_\_YES \_\_\_NO Stroke

\_\_\_YES \_\_\_NO Kidney disease \_\_\_YES \_\_\_NO Blood clots

\_\_\_YES \_\_\_NO Osteoporosis \_\_\_YES \_\_\_NO Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have a preprinted list of prescribed/non- prescribed medication you are currently taking the receptionist can scan into your chart. \_\_\_YES: Please give to staff \_\_\_ NO: Please list meds below.

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Allergies: Latex: \_\_YES \_\_\_NO Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Please list any surgeries, including elective (such as implants) that you have had:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Social History:

Tobacco use: \_\_\_ per day Caffeine use: \_\_\_ per day

Alcohol use: \_\_\_per day Recreational drugs: \_\_\_ per day

1. What is your average level of stress 1-10? (10 being extremely high) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. What decreases your stress? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. What would be your barriers to achieving your goals/expectations from therapy?

\_\_\_ Pain \_\_\_Low energy \_\_\_Lack of support \_\_\_Procrastination \_\_\_ Lack of motivation

\_\_\_ Too many commitments \_\_\_Dislike exercise Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Thank you for taking the time to fill out this questionnaire, we are committed to providing the best possible care to maximize your results.**