BODY In Balance
PHYSICAL THERAPY Palmer, Alaska

Legal Name Last	First.	MI	Preferred Name

☐ Male ☐ Female ☐ _____	Date of Birth	Social Security Number

Mailing Address	City	State	Zip Code

Primary Phone Preferred method of appointment reminders ☐ Voice ☐ Text	Ok to leave detailed messages regarding: Appointment/ Scheduling ☐ Yes ☐ No Billing/Insurance Info ☐ Yes ☐ No
Secondary Phone	Referring Provider Follow up date w/referring provider:
Email Address (for Therapist/Billing communication)	

Emergency Contact Name	Relationship	Phone Number

Are you currently employed? ☐ Yes ☐ No If yes, occupation: _____
Are you currently receiving Home Heath Care? ☐ Yes ☐ No
Prior Military? ☐ Yes ☐ No
Are your injuries covered under an accident related policy? ☐ yes ☐ No
If yes: ☐ Work Comp ☐ Auto ☐ Other _____ Skip to acciendt insurance section
☐ Self pay / I do not currently have medical insurance coverage at this time

Insurance: Please Present Photo ID and insurance cards

Primary Medical Insurance	Secondary Medical Insurance	Tertiary Medical Insurance
Insurance Company Name	Insurance Company Name	Insurance Company Name
Policy Holder's Name	Policy Holder's Name	Policy Holder's Name
Policy Holder's DOB	Policy Holder's DOB	Policy Holder's DOB
Relationship to policy holder	Relationship to policy holder	Relationship to policy holder
Policy Number	Policy Number	Policy Number
Group Number	Group Number	Group Number

Accident Insurance

Insurance Carrier's Name	Claim Number	Date of Injury

Adjustor's Name	Adjustor's Phone Number

Work Comp:	Employer's Name	Employer's Address

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 completed the above information and certify that it is true and correct to the best of my knowledge. I will notify Body In Balance Physical Therapy of any changes to the above information. I authorize Body In Balance Physical Therapy to bill the above listed insurance company(s) on my behalf for all services rendered.

I have received a copy of Body In Balance's Notice of Privacy Practices. I understand that I may request an additional paper copy at any time.

Name: _____

Signature: _____ Date: _____

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Policies & 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. We are committed to providing you with the highest level of care and building a successful provider-patient relationship. A vital part of this relationship is understanding our financial policies. We strive to keep an open line of communication regarding our policies. If you ever have any questions or concerns regarding our fees, policies or responsibilities please feel free to contact our office manager at (907) 746-0722. We accept cash, credit/debit card (MasterCard, Visa, Discover and American Express) money order, and checks. A $35.00 service fee will be charged for all returned checks. **All copayments, coinsurances and deductibles are due at the time of service**.

Insurance

Your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance carrier for covered services that are rendered. It is your responsibility to provide Body In Balance will all necessary information and documents needed to accomplish this. Preauthorization from your insurance company does not guarantee payment from your carrier. We require a governmental photo ID when billing any insurance company. It is the patient's responsibility to know if our office is participating/ in network with his/her insurance plan. Out of network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, and reductions. Our fees are within the usual and customary ranges. If we are not in contract with your carrier, we will not negotiate reduced fees. You, as the guarantor are responsible for all out of network fees and reductions.

Auto / Worker's Compensation

Body In Balance will bill **FIRST PARTY auto claims only.** If your claims are being processed through a third party you will be seen on a self-pay basis, with payment due in full each visit. Body in Balance PT will provide you with claim information for you to submit for reimbursement yourself. You are required to provide Body in Balance with the name of your auto/work comp insurance carrier, claims address, phone number and date of injury. You will be responsible for any charges once your auto insurance/ worker's compensation benefits are depleted.

Overpayments

Patient overpayments will be processed and refunded after all insurance payment/claims have been processed and a final balance has been determined. Refunds will be processed promptly when discovered, but at least quarterly.

Delinquent Accounts

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact our billing department. All delinquent accounts without patient communication will be turned over to Cornerstone Credit Services for collections.

Missed Appointments

We require at least a 24-hour notification for all appointment cancellations. ***A $50.00 no show/ $25 late cancellation fee will be assessed if our office is not notified at least 24 hours prior to your scheduled appointment***. This fee is the patient's responsibility (it will not be billed to insurance) and must be paid before resuming care.

Timeliness of Appointments

We try to see everyone in a timely manner. If we are taking too long, please let your receptionist know so that we may best serve your needs and reschedule your appointment, if necessary.

I am signing that I have read and agree to Body in Balance's Financial Policies

Name: _____

Signature:_____ Date:_____

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Assignment of Benefits

I understand that services rendered to me by Body In Balance Physical Therapy are my financial responsibility and that Body in Balance can bill my insurance as a courtesy.

I authorize Body in Balance Physical Therapy to bill my insurance policy(s) on file.

I authorize my insurance company, listed on the prior pages, to pay my benefits (send payment for services rendered) directly to Body in Balance Physical Therapy, 642 S. Alaska St Ste 209, Palmer, AK 99645. This is a direct assignment of my rights and benefits under this policy.

I agree to pay, and keep my account current, for any balances for professional service charges over and above insurance payments.

I authorize Body in Balance Physical Therapy to release all information necessary to adjudicate my claims.

I understand that Body in Balance is contractually obligated to collect deductibles, copayments, and co-insurances in full for all insurances that they are contracted with.

If my insurance company makes a payment directly to me for services rendered by Body in Balance I will forward the payment to Body In Balance within 48 hours.

I authorize Body in Balance to initiate a complaint or file an appeal to the insurance commissioner or any payer authority on my behalf, as needed. I agree to be active in the resolution of claims that are delayed, denied, or reduced.

Name: _____

Signature: _____ Date:_____

Patient Name: _____Date of Birth: _____

General Patient Information – New Patient

Any major changes to your medical history or medications since your last visit? ☐ Yes ☐ No

Are you receiving any PT, OT, Speech, or massage at a different location? ☐ Yes ☐ No

What is your main complaint or injury? _____

When did this episode begin? _____

How did your problem start? _____

Did you have surgery for this injury? ☐Yes ☐ No Date of Surgery: _____

Do you have a history of similar episodes/complaints? ☐Yes ☐ No

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

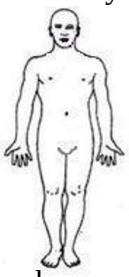
List three activities that you are unable to do because of your current complaint or injury.

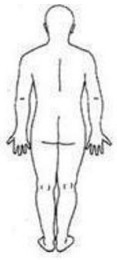
1. _____ 2. _____3. _____

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	

Please indicate the painful areas by shading the model:

Right side  Left side

Left side  Right side

What positions/activities make your pain worse? _____

What positions/activities lessen your pain?_____

Does your current complaint affect your sleep? ___YES ___NO

Have you had an x ray, MRI or CT scan for your current injury? ___YES ___NO

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: _____

Additional information you would like your Physical Therapist to know:

_____

_____

Medical History

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: _____

Are you receiving treatment for any other medical conditions? ☐ Yes ☐ No

If yes, please list: _____

Please list any surgeries, including elective (such as implants) that you have had:

1. _____ Reason: _____
2. _____ Reason: _____
3. _____ Reason: _____

Allergies: Latex: ☐ Yes ☐ No Other:_____

Medications - *If you have a list the receptionist can make a copy for our records.

1._____ Reason: _____
2._____ Reason: _____
3._____ Reason: _____

Current Height ____ ft ____in Weight _____ lbs

Social History

Are you currently working outside of the home? ☐ Yes ☐ No

Do you have children? ☐ Yes ☐ No How many? _____

Tobacco use: ___ per day Caffeine use: ___ per day

Alcohol use: ___per day Recreational drugs: ___ per day

What is your average level of stress 1-10? (10 being extremely high) _____

What decreases your stress? _____

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: _____