PHYSICAL THERAPY SERVICES
OF BRATTLEBORO, INC.
30 Harris Place, Brattleboro, VT 05301
Phone: 802.254.4699 Fax: 802.257.1985

PATIENT INFORMATION

Please Print

Patient Name_____ Date of Birth_____ Age_____
Responsible Party if Minor_____
Mailing Address_____City_____State_____Zip_____
Street Address_____City_____State_____Zip_____
Home Phone #_____Work Phone #_____Cell Phone #_____
Social Security #_____E-Mail Address (optional)_____
Employer_____Address_____City_____Zip_____
Occupation_____ Referred by_____

. **PRIMARY INSURANCE TO BE BILLED**_____
. Address_____City_____State_____Zip_____
. Certificate #_____Group #_____
. Telephone #_____ ***Subscriber's Name*** _____
.
. **SECONDARY INSURANCE TO BE BILLED**_____
. Address_____City_____State_____Zip_____
. Certificate #_____Group #_____
. Card Holders Name_____
.
. **IS THIS A WORKMANS COMP CLAIM?** Y / N Injury Date_____
. Was this injury reported? Y / N Claim #_____
. Contact Person_____Telephone_____
.
. **CAR ACCIDENT** Y / N Injury Date _____ Insurance Co._____
. Address_____City_____State_____Zip_____
.
. **LITIGATION** Y / N If yes, Attorney's Name_____
. Address_____City_____State_____Zip_____
.
. Have you had Physical Therapy before? Y / N If so where? _____
. Have you had ***any*** Home Health in the last 60 days for ***any reason***? Y / N

AUTHORIZATION

I HEREBY GIVE CONSENT FOR TREATMENT AND AUTHORIZE PHYSICAL THERAPY SERVICES OF BRATTLEBORO, INC. TO FURNISH & RECEIVE INFORMATION RELATED TO THIS ILLNESS OR ACCIDENT TO/FROM MY INSURANCE CARRIER, ATTORNEY, OR OTHER MEDICAL PERSONNEL
DATE_____SIGNATURE_____

PHYSICAL THERAPY SERVICES OF BRATTLEBORO, INC. accepts third party billing. We will send your insurance claims to the address you provide, on a weekly basis. **It is your responsibility** to call your insurance company to check on the coverage provided by your individual policy. **Medicare & Medicaid require a doctor's referral.** If your particular insurance also requires a referral, you should have your referring provider forward the referral to our office. **Medicare also requires a signed plan of car from your referral source.**

If we have not received payment from your insurance carrier within 45 days, we expect payment from you directly. Your insurance contract is between you and your carrier. We submit claims as a courtesy to you. **You are directly responsible for the payment of our services.** Occasionally, insurance companies may not cover certain physical therapy treatment procedures (such as, but not limited to: Dry Needling, iontophoresis, massage, mechanical traction, and ultrasound). If your insurance will not pay for these procedures you can chose to pay for that procedure yourself, or you can decline the procedure in question. The choice is always yours. If you are unsure whether or not a procedure is covered it is your responsibility to find out. There are numerous policies and each is different so **we <u>cannot</u> advise you about your coverage.**

Our fees are generally considered to fall within the acceptable range by most insurance companies, and therefore are covered up to the maximum allowable amount determined by each carrier. This applies only to companies who pay a percentage of usual, customary, and reasonable fees (UCR). Thus, our fees are considered usual, customary, and reasonable.

This statement does not apply to all companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.

For **accounts in litigation**, we will bill your auto/health insurance directly. Please remember that **you are responsible** for payment of your bill, not the individual being sued. Liability action against someone else will not enable you to refuse payment to us. If you do not have auto/health insurance we will require the promise of payment (a lien on your settlement) which you must file with your lawyer and return the original to our office within one week after starting physical therapy.

THERE WILL BE A $25 CHARGE FOR EACH MISSED APPOINTMENT THAT ISN'T CANCELLED WITH AT LEAST 24-HOUR NOTICE. THIS CHARGE WILL BE TO YOU, THE CLIENT OR RESPONSIBLE GUARDIAN, NOT YOUR INSURANCE COMPANY. WE ALSO RESERVE THE RIGHT TO REFUSE TREATMENT FOR ANY CLIENT THAT HAS FAILED TO SHOW FOR 3 OF MORE APPOINTMENTS. LATE ARRIVAL OF 15 MINUTES OR MORE WILL BE CONSIDERED A "FAIL TO SHOW".

If you would like to submit your own claims to your insurance company, we will require payment at the time of treatment.

****We would like patients with a co-pay to pay that amount at the time of treatment. ****

If during the course of treatment your insurance company changes, **it's your responsibility to let us know immediately**.

If you have any questions, please feel free to ask our Office Manager, and other arrangements can always be made.

Please initial_____

*Please complete information on other side.

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PATIENT INFORMATION CONSENT FORM

I have read and fully understand Physical Therapy Services of Brattleboro, Inc.'s Notice of Privacy Practices. I understand that Physical Therapy Services of Brattleboro, Inc. may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Physical Therapy Services of Brattleboro, Inc. will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions, unless I have paid for the service or health care item out-of-pocket in full.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Physical Therapy Services of Brattleboro, Inc.'s Notice of Privacy Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____
Patient Name

_____
Signature of Patient or Patient's Personal Representative

_____
Date

***** This authorization is effective for one year from the date it is signed unless later revoked.*****

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment (including appointment dates/times), payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified (by having them provide us with your date of birth) before Physical Therapy Services of Brattleboro, Inc. will release any information to any of the designees listed below.

Authorized Designees:

☐ I do not wish to designate anyone

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

_____
Patient Name

Patient's Date of Birth: _____/_____/_____

_____
Patient or Patient's Personal Representative Signature

_____
Date

Outpatient Health History

NAME:		TODAY'S DATE:
DATE OF BIRTH:	GENDER: ☐ M ☐ F	☐ Right handed ☐ Left handed

MEDICAL/SURGICAL HISTORY

Please check if you have ever had:

☐ Arthritis	☐ Lung/Breathing Problems	☐ Allergies
☐ Broken bones	☐ Diabetes/High Blood Sugar	☐ Thyroid Problems
☐ Osteoporosis	☐ Stroke	☐ Cancer
☐ Blood Disorder	☐ Head Injury	☐ Infectious Diseases (TB, Hepatitis)
☐ Circulation Problems	☐ Multiple Sclerosis	☐ Kidney Problems
☐ Heart Problems	☐ Parkinson's Disease	☐ Drug Resistance Infections
☐ High Blood Pressure	☐ Seizures/Epilepsy	☐ Ulcers/Stomach Problems
☐ Depression/Anxiety	☐ Skin Disorders	☐ Other:

Please check if you have experienced the following symptoms in the past year:

☐ Chest pain	☐ Loss of balance or falls	☐ Bowel problems
☐ Heart palpitations	☐ Difficulty in walking	☐ Weight loss/gain
☐ Cough	☐ Joint pain or swelling	☐ Urinary problems
☐ Hoarseness	☐ Pain at night	☐ Fever/chills/sweats
☐ Shortness of breath	☐ Difficulty sleeping	☐ Headaches
☐ Dizziness or blackouts	☐ Loss of appetite	☐ Hearing problems
☐ Coordination problems	☐ Nausea/Vomiting	☐ Vision problems
☐ Weakness in arms or legs	☐ Difficulty swallowing	☐ Other:

Have you ever had surgery? ☐ yes ☐ no If yes, please describe and provide date

	Date:
	Date:
	Date:

MEDICATIONS

Do you take any prescription medications? ☐ yes ☐ no If yes, please list below:

Do you take any non-prescription medications? ☐ yes ☐ no If yes, please check all that apply:

☐ Aleve/Naproxen	☐ Tylenol/Acetaminophen	☐ Antacids
☐ Advil/Ibuprofen	☐ Antihistamines	☐ Herbal Supplements
☐ Aspirin	☐ Decongestants	☐ Other:

DIAGNOTIC TESTS

Please indicate if you have had any of the following tests within the past year?

☐ X-rays	☐ Bone Scan	☐ EKG (electrocardiogram)	☐ Echocardiogram
☐ CT Scan	☐ Arthroscopy	☐ Angiogram	☐ Pulmonary Function Test
☐ MRI	☐ EMG (electromyogram)	☐ Stress Test	☐ Bronchoscopy
☐ Myelogram	☐ NCV (nerve conduction velocity)	☐ Ultrasound	☐ Other:

SOCIAL HISTORY

Where do you live?	☐ Private Home	☐ Apartment	☐ Rented Room
	☐ Assisted Living	☐ Group Home	☐ Other:
Does your home have:	☐ Stairs, no rail	☐ Stairs, rails	☐ Ramp
	☐ Elevator	☐ Uneven terrain	☐ Assistive Equipment (i.e. bath)
Do you use:	☐ Cane	☐ Walker	☐ Crutches
	☐ Manual WC	☐ Motorized WC	☐ Leg Braces

Do you: ☐ Smoke ____ ppd ☐ Drink alcohol, ___/week ☐ Exercise, ___x/week for ___ mins.

Rate your General Health Status: ☐ excellent ☐ good ☐ fair ☐ poor

_____

Signature of person providing this information