

**BENTZ PHYSICAL THERAPY
PATIENT INFORMATION FORM**

Referring Physician _____ Primary Physician _____

PERSONAL INFORMATION Male Female Married Single Divorced Widowed

Name _____ SS# _____ Date of birth _____

Physical Address _____ Apt.# _____

City, State, Zip _____

Ph. # _____
Home Cell Business Ext.

Employer _____ Job Title _____

Address _____
Street City Zip

Emergency Contact _____

Relationship _____ Ph # (____) _____

PRIMARY INSURANCE CARRIER (Name of ins. co.) _____

Name of insured _____ Insured's ID# _____

Relationship to patient (check one) Spouse Parent Other

Insured's date of birth _____ Group # _____

Insured's Employer _____

Was injury due to an auto accident? Yes No

WORKER'S COMPENSATION INFORMATION / PERSONAL INJURY PROTECTION

Insurance Carrier _____

Date of injury _____ Claim # _____

Adjuster's name _____ Ph. # (____) _____
Ext.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize Bentz Physical Therapy to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for related services. I authorize the payment of medical benefits to Bentz Physical Therapy. I understand that I am financially responsible for all copayments, deductibles, co-insurance and services NOT COVERED under my benefits plan. I have received and understand the credit and collection policy of this company and agree to abide by the policy stated therein. I have read and completed this information sheet and certify this information is true and correct to the best of my knowledge.

SIGNATURE _____ DATE _____

_____Bentz Physical Therapy_____

PATIENT INFORMATION CONSENT FORM

I have read and fully understand Bentz Physical Therapy's Notice of Information Practices. I understand that Bentz Physical Therapy 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 Bentz Physical Therapy will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

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

Patient Name

Signature

Date

I also authorize Bentz Physical Therapy to use my protected health information for targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

Patient Name

Signature

Date

BENTZ PHYSICAL THERAPY PATIENT POLICY

Thank you for choosing Bentz Physical Therapy for your rehabilitation needs. We are committed to providing you with the best possible care. If you have health insurance, we are anxious to help you receive the maximum allowable benefit. In order to achieve these goals, we need your assistance and acknowledgment of our policy. Please follow these guidelines as you complete the required paperwork.

1. Fill out the forms thoroughly and completely.
2. If the patient is not the insurance subscriber, we will need the information requested about the subscriber, including name, social security number, and the subscribers date of birth. We will also need the employment information of the subscriber.
3. If the patient is a minor (under the age of 18), we will need the social security number and date of birth of the patient. We will also require that a parent or legal guardian sign the paperwork. Responsibility for treatment of minor children, whose parents are divorced, rests with the parent who seeks treatment.
4. If your insurance requires preauthorization and/or referral for physical therapy, it is your responsibility to ensure that the referring physician or your PCP has obtained the necessary preauthorization. If we do not have the proper authorization or referral at the time of your visit, it may be necessary to reschedule your appointment or, you may be required to pay for your visit in full. In the event that we are paid for the service by your insurance company, you will be reimbursed for the visit, less any applicable co-pay or deductible.
5. Co-payments, deductibles, supplies and DME (Durable Medical Equipment) charges will be collected at the time of service.
6. If you are on Medicare, we do accept assignment. We require that you meet the deductible on your policy. Medicare will automatically file or "cross over" with many secondary insurance carriers. If your secondary does not "cross over", we will file it after Medicare pays their portion. You will be responsible for the amount your secondary does not pay. If you do not have a secondary, you will be responsible for any co-insurance that Medicare does not cover.
7. Workers Compensation patients are responsible for providing us with all billing and contact information regarding their claim. If this information is not complete, we may need to reschedule your appointment until you are able to provide us with the required information. It is not the responsibility of your physician's office to provide this information.
8. We do treat Automobile Accident patients. We will first file with your automobile PIP (Personal Injury Protection). If you do not have PIP, and if your medical insurance will pay for your automobile accident, then we will file with your medical insurance. All other automobile accident patients will be seen on a cash pay basis. We will not accept a Letter of Protection from your attorney as a guarantee of payment or a third party insurance payment.
9. Please provide us with a current, legible copy of your insurance card and a picture ID. We will need to make a photocopy of these for our records.
10. We accept cash, check, Mastercard, Visa, American Express, and Discover cards. There will be a \$25.00 charge for any returned check.
11. Failure to abide by this policy or if we do not receive payment within 60 days will result in our taking the necessary action to collect payment.

We look forward to having you as a patient and appreciate your consideration in following our patient policy.

BENTZ PHYSICAL THERAPY CONFIDENTIAL HEALTH HISTORY

Name: _____ **Date:** _____ **Gender:** Female Male
Age: _____ **Weight:** _____ **Occupation:** _____ **Last day worked (if applicable):** _____

Is anyone currently coming to your home to give you health care? Yes No

Current Symptoms: Describe the problems you are experiencing currently.

How did your symptoms begin? Trauma, gradual, sudden? _____

When did you first notice these symptoms? (Use specific day if trauma/accident) _____

Date of most recent flare up: _____

Describe your symptoms: _____

Using the diagram below, mark all area(s) where you are experiencing symptoms.

Use the symbols to describe symptoms:

Are your symptoms?:

- Getting better
- Staying the same
- Getting worse

Aching Numbness Pins and needles Burning Stabbing

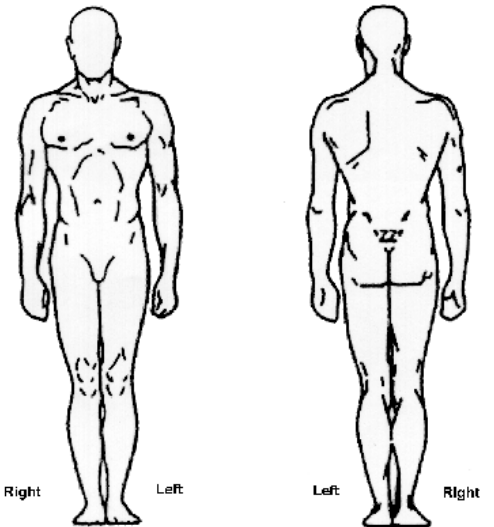
**** ===== OOOO XXXX ///

What makes your symptoms WORSE?:

- Walking / Standing _____
- Sitting / Bending _____
- Lying Down (face up / face down / side)
- Movement _____
- Other _____

What makes your symptoms BETTER?:

- Walking / Standing _____
- Sitting / Bending _____
- Lying Down (face up / face down / side)
- Movement _____
- Other _____



Frequency of symptoms:

- Constant (76-100% of the day)
- Frequent (51-75% of the day)
- Occasional (26-50% of the day)
- Intermittent (0-25% of the day)
- Less than Daily _____

Please rate your pain:

0	1	2	3	4	5	6	7	8	9	10
None			Moderate				Need to go to ER/hospital			

Have you had any injections or other treatment for these symptoms? No / Yes Dates _____

Which tests have you had for this condition? X-ray MRI EMG CT Bone scan Other

Describe the test results _____

When is your next appointment with the doctor who requested this therapy? _____

Are you CURRENTLY under the care of another health professional in addition to the one prescribing Physical Therapy? No / Yes For what condition(s): _____

Have you ever had physical/occupational therapy prior to this occasion? No / Yes

Prior Function and Environment

Please describe your living arrangements *prior* to the onset of this condition:

- House Apartment With spouse/family member Alone Daytime caretaker Other _____

Who is responsible for household tasks such as cleaning and preparing meals?

- Self Spouse/family member Daytime caretaker Other _____

How often did you drive yourself around the community?

- Always Frequently Occasionally Rarely Never

When you are out in the community, do use an assistive device?

- Wheelchair Walker Cane Crutch(es) Other _____

Medical History (Check all conditions you **HAVE** or **HAD** in the past) Check box if **NO** to all below

<input type="checkbox"/> AIDS	<input type="checkbox"/> Changes in vision/hearing	<input type="checkbox"/> HIV positive	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Depression	<input type="checkbox"/> Joint pain	<input type="checkbox"/> Pregnant NOW /RECENT
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Low blood sugar	<input type="checkbox"/> Psychiatric care
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Smoker ____ # packs/week
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> Weight gain / loss
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fractures / dislocations	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Heart attack / disease
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Myofascial pain syndrome	<input type="checkbox"/> Heart surgery
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Neurological disorders	<input type="checkbox"/> Chest pain
<input type="checkbox"/> Bowel or bladder difficulty	<input type="checkbox"/> Hernia	<input type="checkbox"/> Night sweats	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Bulimia	<input type="checkbox"/> Hemorrhaging	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cancer	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Persistent night pain	<input type="checkbox"/> Other

Medications (List all medicines you are currently taking) Allergies (Substances/medicines)

Surgeries (List ALL previous procedures. Eg heart, abdominal, bone, ligament, other)

Patient Goals: What do you hope to gain through therapy?

- Decrease pain Increase motion Return to specific activity _____
 Increase strength Improve function Other _____

Do you use the internet to learn about your health/ your current condition?: No / Yes

What would be your ideal physical therapy treatment:

- Have regular assistance/guidance with exercises. Just show me how to do so I can do on my own
 To learn about what the problem and the solution. I just want help to fix the problem

Please rank the following in regard to your health care needs: (1= most important, 4= least important)

____ Experience ____ Outcomes ____ Price ____ Convenience

Please rank how you see yourself/ your personality: (1= most , 4= least)

____ Guardian ____ Artisan ____ Idealist ____ Rationalist

Thank you for taking time to complete this evaluation. Our staff hopes to provide you with excellent care to reduce your symptoms and restore you to normal function.

Patient signature _____
Therapist Signature _____

Date _____
Date _____

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, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Patient Name

Patient Signature

Date