BENTZ PHYSICAL THERAPY
PATIENT INFORMATION FORM

Referring Physician _____ Primary Care Physician _____

Name _____ Home Phone _____

Address _____ Apt _____ Cell Phone & Carrier _____

City, State, Zip _____ Email address _____

Date of Birth ___/ ___/ ____ Male ___ Female ___ Married ___ Single ___ Other ___ Employed ___

SS# _____ Student: Yes ___ No ___ If Yes, Full Time ___ Part Time ___

Occupation _____ Employer _____

Employer Address _____ Work Phone _____

City, State , Zip _____

Emergency Contact Name _____ Phone _____ Relationship _____

Insurance Company _____ ID# _____ Group# _____

Insurance Policy Holder _____ Relationship to Patient: Self ___ Spouse ___ Parent ___

Date of Birth of Policy Holder (if different than self) ___/ ___/ ___ Phone (if different than self) _____

Address of Policy Holder (if different than self) _____

Employer of Policy Holder (if different than self) _____

If patient is under 18 years of age, name of Responsible Party _____

Responsible Party address & phone _____

Secondary Insurance Company _____ ID# _____ Group # _____

Nature of Injury: Auto Accident ___ Work Related ___ Other ___ No Injury, I just have pain or difficulty ___

Date of Injury ___/ ___/ ___ Date of Surgery ___/ ___/ ___

If Work Related: Claim# _____ Adjuster _____

Adjuster Phone _____ Adjuster FAX_____

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 POLICY

Thank you for choosing Bentz Physical Therapy for your rehabilitation needs. We are committed to providing you with the best possible care. In order to achieve the goals we have set with you, 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 you are not the insurance subscriber, we will need the name, date of birth, and employer information concerning the subscriber.
3. If you are under the age of 18, we require that a parent or legal guardian sign the paperwork. Responsibility for treatment of minor children rests with the person seeking treatment and whoever signs the paperwork.
4. If your insurance requires preauthorization and/or a 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 will 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. **If you are late for your appointment by more than 10 minutes, we will require you to re-schedule, or wait for the next available opening.**
6. **If you wish to change or cancel your appointment, we require a minimum 24 hour notice. Anything less will result in a $20 fee charged to your account.** Whether you attend or not we still accrue the expense for staff wages, rent, etc. We do not charge you the actual cost for that appointment but rather a $20 fee. Advance notice allows someone else the opportunity to schedule in place of you. Please be courteous and responsible. Thank you
7. **If you fail to show for an appointment without notice all future appointments will be removed and a $20 fee assessed to your account. You may re-schedule appointments on a first come first serve basis.**
8. We will verify your insurance benefits as a courtesy to you, based on the information that you provide to us. We will notify you prior to treatment of your insurance benefits and your financial responsibility. The benefits that we receive from your insurance company may not be accurate. We encourage you to find out and know what your insurance company pays for outpatient physical therapy in an office setting.
9. Please provide us with a current legible copy of your insurance card and a photo ID. We will make a photocopy for our records.
10. Co-payments, deductibles, supplies and DME (Durable Medical Equipment) charges will be collected at the time of service. We accept cash, check, Mastercard, Visa, Discover and American Express. There will be a $25 charge for any returned checks.
11. If you do not have insurance, and/or you wish to pay cash; Our Initial Evaluation fee is $125.00, and each subsequent visit will be $100.00. If you wish to pay for 10 treatments in advance, the price will be $900.00. Under these conditions we will not file any insurance claims for you.
12. 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.
13. I authorize Bentz Physical therapy to contact me via current and future cellular phone number(s), email address, or wireless device(s) regarding my delinquent account(s) I owe to Bentz Physical Therapy. I authorize and its agents, representatives, attorneys (including collection agencies) to use automated telephone dialing equipment, artificial pre-recorded voice or text messages and personal calls and emails, in their effort to contact me for purposes of collecting any portion of my account which is past due.

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

Revised August 2015

_____ _____

Date Signature

BENTZ PHYSICAL THERAPY

Authorization of Use and Disclosure of Protected Health Information (PHI)

I understand that, under the Health Insurance Portability & Accountability Act of 1996, as amended and supplemented (HIPPA), I have certain rights to privacy regarding my protected health information (PHI). PHI may originate in your medical record at Bentz Physical Therapy, or may be received from outside health entities and filed in your medical record.

I understand that this information can and will be used by Bentz Physical Therapy, to: (a) Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly, (b) Obtain payment from third-party payers, (c) Any such other purposes permitted under HIPPA.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Bentz Physical Therapy has the right to change its Notice of Privacy Practices from time to time, and that I may obtain a current copy of the Notice of Privacy Practices by contacting the Privacy Officer at 1109 8th Avenue, Fort Worth, TX 76104.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you may have taken action relying on this consent.

Designation of Those Who Can Receive Information About My Care

I designate the following individuals to have access to information about me that is created by or on behalf of Bentz Physical Therapy, and that this information can include PHI. I understand that I may revoke this designation at any time by completing a new form, and that this designation will not expire until I actively revoke it. I understand that these individuals will not be able to request a paper or electronic copy of my health records without having completed an Authorization to Release Medical Information form.

I understand that my healthcare treatment or payment, or my enrollment or eligibility for benefits cannot be conditioned on my designating or not designating an individual below.

I understand that this designation does NOT allow for the release of any information concerning drug abuse, alcohol abuse, psychological or psychiatric conditions, HIV/AIDS status, abortion, or sexually transmitted disease, if any.

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

Text Messaging Consent: I consent to receiving text messages from Bentz Physical Therapy to the wireless number that I have provided to Bentz Physical Therapy. This may include appointment information.

YES _____ (patient initial) NO _____ (patient initial)

Email Consent: I consent to receiving email messages from Bentz Physical Therapy to the email address that I have provided to Bentz Physical Therapy. I understand that these emails are unencrypted, and are not secure. This may include appointment information.

YES _____ (patient initial) NO _____ (patient initial)

_____	_____	_____
Patient Name	Signature	Date
_____	_____	_____
Patient Representative if Patient is a Minor	Signature	Date

BENTZ PHYSICAL THERAPY- Confidential Health History

Name:_____ Date:_____ Age:_____ Height:_____ Weight:_____

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

Please describe the problems/symptoms you are currently experiencing:_____

_____

_____

How/When did you symptoms begin?_____

_____

Overall are your symptoms?: ☐ Getting Better ☐ Staying the same ☐ Getting Worse

What makes your symptoms WORSE?_____

BETTER?_____

How often do you experience your symptoms? ☐Constant ☐Frequent ☐ Occasional ☐ Intermittent ☐Other_____

What tests, treatments or procedures have you had for these symptoms or condition?_____

_____

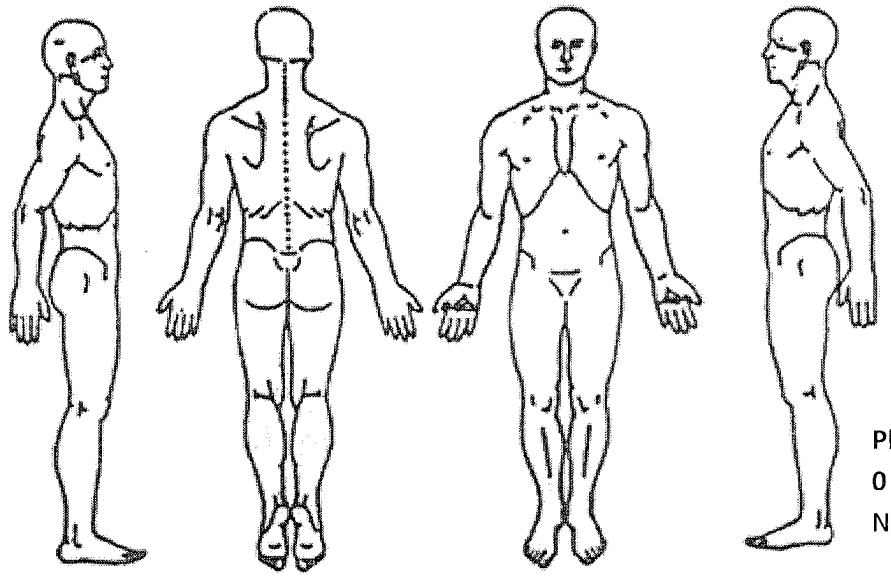
Do you have a follow up appointment with the doctor that referred you for physical therapy? ☐No ☐Yes, Date:_____

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

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

___Experience ___Outcomes ___Price ___Convenience

Using the diagram below, mark all area(s) where you are experiencing symptoms (Use the symbols to describe symptoms)



Aching *****

Numbness ====

Pins and Needles ooooo

Burning XXXX

Stabbing /////

Please Rate your pain:

0 1 2 3 4 5 6 7 8 9 10

None Moderate Severe

Medical History (Check all conditions you **HAVE** or **HAD** in the past)

☐Anemia	☐Cancer	☐HIV positive	☐Psychiatric care
☐Arthritis	☐Diabetes	☐Neurological disorders	☐Smoker
☐Asthma	☐Dizziness	☐Night sweats	☐Stroke
☐Allergies	☐Fractures dislocations	☐Pacemaker	☐High blood pressure
☐Bleeding disorders	☐Fibromyalgia	☐Persistent night pain	☐Chest pain
☐Bowel or Bladder difficulty	☐Hernia	☐Pregnant NOW/RECENT	☐Other_____

Surgeries (List ALL previous procedures Ex. Heart, abdominal, bone, ligament, other)_____

_____

Allergies (Substances/Medications)_____

_____

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

Name:_____ Date:_____

Medications, Over-the Counters, Herbals, and Supplements

(List all medicines you are currently taking, as well as dosage, frequency, and route of administration)

Name	Dosage	Frequency	Route	Purpose of taking