428 Long Hill Rd., Groton, CT 06340
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besthealthpt@gmail.com
www.besthealthpt.com

PATIENT INFORMATION

Please present insurance cards to receptionist

FIRST NAME: ______________________________________ M.I.:________LAST NAME: ______________________________

DATE OF BIRTH: _____-_____-________ SEX: ☐ MALE ☐ FEMALE EMAIL: ____

ADDRESS: ____ APT#: _______

CITY: _____________________________________ STATE: ________________ ZIP CODE: ____________

HOME #: (______) ________-____________ CELL#: (______) ________-____________ WORK #: (______) ________-____________

MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ OTHER ________________________________

EMERGENCY CONTACT: NAME - ____ PHONE (_____) _______ - ________

Please fill out only if you're NOT the subscriber

NAME OF INSURED: ___________________________ DATE OF BIRTH: _____________________________

ADDRESS IF DIFFERENT THAN PATIENT: ____

CITY: ___________________ STATE: _________ ZIP: __________ PHONE :(____) ________-__________

RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER SS#:________-_______-________

ADDITIONAL INSURANCE: ☐ YES ☐ NO IF YES, NAME OF INSURED: ____

IS YOUR CONDITION: ☐ WORK RELATED ☐ AUTO ACCIDENT

DATE AND TYPE OF INJURY/SURGERY: _____-_____-____

Additional medical problems: ____

What Medication are you currently taking? ____

Do you have any previous history of?

Past	Present		Past	Present		Past	Present	
☐	☐	Diabetes	☐	☐	Kidney Stones	☐	☐	Emphysema
☐	☐	Ulcer	☐	☐	Kidney Disorders	☐	☐	Heart Attack
☐	☐	Anemia	☐	☐	High Blood Pressure	☐	☐	Prostrate Problems
☐	☐	Hernia	☐	☐	Depression	☐	☐	Arthritis
☐	☐	Stroke	☐	☐	Rapid Heart Beat	☐	☐	Aortic Aneurysm
☐	☐	Asthma	☐	☐	Angina (Chest Pain)	☐	☐	Cancer
☐	☐	Pacemaker	Other, please describe					

Other, please describe ____

Have you been admitted to the hospital or undergone any surgical procedures in the last 5 years? Yes ☐ No ☐

If so, what was the condition? ____

Is this condition the reason you were referred to Physical Therapy? Yes ☐ No ☐

Have you received any physical therapy treatments during the past 5 years? Yes ☐ No ☐

If yes, for what condition and was the treatment effective? ____

What was this treatment? ____

Have you had any previous orthopedic problems? Yes ☐ No ☐ If yes, please specify: ________________________

Are you pregnant? Yes ☐ No ☐ Height _______ Weight _______

PATIENT INFORMATION RECORD

Why are you here: ____

Where is your problem? (Please Circle) Ankle Knee Hip Elbow Shoulder Back Wrist Other_________________

Which Side? (Please Circle) Left Right Both

Dominant Arm? (Please Circle) Left Right

Type of work, examples: lifting, prolonged sitting, standing, keyboarding etc. _________________________________

____

Please describe character of your current pain. (You may check more than one answer)

☐ sharp ☐ stabbing ☐ burning ☐ dull ☐ aches ☐ tingling ☐ numbness ☐ soreness ☐ weakness ☐ shooting ☐ throbbing

How often are the complaints present?

☐ Constant (76-100%) ☐ Frequent (51-75%) ☐ Occasional (26-50%) ☐ Intermittent (25%)

Please rate the severity of your pain. (Please circle a number below) 0 = No Pain 10= Unbearable Pain

CURRENT 0 1 2 3 4 5 6 7 8 9 10 **BEST** 0 1 2 3 4 5 6 7 8 9 10 **WORSE** 0 1 2 3 4 5 6 7 8 9 10

Since your problem started, is the pain: ☐ Increasing ☐ Decreasing ☐ Not Changing

Do your symptoms change throughout the day? ☐ Yes ☐ No

Problem began: ☐ Immediately after a trauma or specific incident ☐ Multiple incidents ☐ Developed over time

What aggravates your symptoms? ____

What eases your symptoms? ____

What treatment have you received for this present condition? ☐ Surgery ☐ Spinal Injection ☐ Physical Therapy

☐ Chiropractor ☐ None ☐ Other ____

Have you ever had similar episodes before? ☐ Yes ☐ No

Have you, or are you currently being treated by another healthcare practitioner for this problem? ☐ Yes ☐ No

If yes, by: ☐ Chiropractor ☐ MD ☐ Other

Have you had any of the following for this condition? ☐X-ray ☐ MRI ☐ CT scan ☐ EMG ☐ Myelogram ☐ Discogram

Have you had any changes in bowel or bladder function? ☐ Yes ☐ No

Do you have fever, chills, or night sweats? ☐ Yes □ No

Activity Level: (Please Circle) None Recreational Competitive

Describe current limitations in your daily activities: ____

What are your goals for Physical Therapy? ____

Name of Referring Physician ____

Name of Primary Care Physician ____

Non-physician referral to BHPT? ____

Patient Signature ____**Date** _________________

INSURANCE AND FINANCIAL INFORMATION

Please carefully read the following: INSURANCE IS NOT A SUBSTITUTE FOR PAYMENT: Call your insurance company if you have any questions. You are ultimately responsible for payment for any services rendered that are not paid by your insurance company.

Private Insurance: You are responsible for your deductible, and co-payment, at the time of service. **BHPT** will verify eligibility of benefits of your private insurance and inform you of your financial responsibility at your first visit. Once your insurance company has paid their portion; you will receive an invoice for any remaining balance. If you wish us to bill secondary insurance to you must provide us both cards at the first visit. In order to avoid delays on insurance reimbursement, please immediately inform the office staff of any change of insurance plans.

Medicare: The Medicare cap for non-exempt diagnosis is $1900.00. Currently, Medicare covers 80% of approved charges for out-patient physical therapy services, (combined with occupational, speech and rehab therapies) provided that your annual deductible has been met. Medicare patients who have a supplemental insurance (recognized by Medicare) must give both cards to the front office so we may bill them for the remaining 20% of Medicare approved charges. Otherwise, the patient is responsible for the 20% not covered by Medicare.

Workers Compensation: We will verify your workers' compensation claim and obtain authorization for treatment with your employer's insurance company. Only authorized visits will be scheduled. If your claim is delayed or denied, we will notify you immediately. It is important that you provide us with updated referrals to continue therapy. Documentation of any missed appointments is forwarded to your Case Manager and Primary Physician and this could jeopardize your claim.

Personal Injury Cases: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case. Documentation of any missed appointments is forwarded to your Case Manager and Primary Physician and this could jeopardize your claim.

Self-Pay: We do offer non-insurance/out of pocket plans. If you wish to bill your own insurance, we require payment in full at the time of service. We will provide you with a statement of charges and a copy of the physician's referral.

Cancellation Fee/Broken Appointments: $25 will be charged for failing to notify us 24 hours in advance that you are unable to make your scheduled appointment.

NSF-Check Return: $25 fee will be charged if a check is returned for insufficient funds or a closed account.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Note: As a courtesy, **BHPT** will bill your insurance company for you. If you have no insurance coverage, a large deductible, or financial hardship, please speak to the front office personnel regarding a payment plan.

Authorization to pay/ financial agreement

I hereby authorize my insurance benefits to be paid directly to Best Health Physical Therapy for services I receive.
I expressly guarantee payment of any charges left unpaid in whole or in part or determined to be not medically necessary by the Insurance Company. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I also Authorize **BHPT** to release any information to process this claim and secure the payment of benefits, insurance company, attorneys, assignees and or beneficiaries. I further agree that a photocopy of this agreement shall be valid as the original.

___________________________________ ____ __________

Patient's Printed Name **Patient's Signature** **Date**

Patient Acknowledgment

I acknowledge that I have read a copy of the Notice of Privacy Practices of **BHPT**. I further acknowledge that a copy of the current notice is posted in the reception area.

_______________________________ ____ _________

Patient's Printed Name **Patient's Signature** **Date**