



Patient Information

Please fill in all blank areas that apply to you unless otherwise informed. If your information changes we need to be notified **as soon as possible**. If we are not informed you will be responsible for your balance.

Method of contact; if you prefer a specific method other than by phone please inform the office staff when filling out this form, otherwise we will use the numbers listed below.

Name _____ SS# _____ - _____ - _____

First _____ **M.** _____ **Last** _____
DOB ____/____/____ Home Phone (____) _____ Cell (____) _____

Primary Physician _____ Referring Physician (if any) _____

____ Please initial if you would like for us to send a copy of your report to your Primary Care Physician.

Email _____ **Status (circle one):** Single Married Other

Address _____ City _____ ST _____ Zip _____

Out of State Address _____

In case of emergency notify: _____ Relationship: _____

Emergency Contact Home Phone: _____ Emergency Contact Cell Phone: _____

Are you retired? YES /NO (*If not retired please complete information below*)

Employer _____ Phone (____) _____ Ext. _____

Address: _____

Primary Insurance Name _____ **Are you the primary Subscriber: YES NO**
If no please fill out information below.

Relationship to patient: Self _____ Spouse _____ Child _____ **Insured's DOB** ____/____/____

Insured's Name _____ **Insured SS#** _____ - _____ - _____

Secondary Insurance Name _____ **Are you the primary Subscriber: YES NO**
If no please fill out information below.

Relationship to patient: Self _____ Spouse _____ Child _____ **Insured's DOB** ____/____/____

Insured's Name _____ **Insured SS#** _____ - _____ - _____

a. If your injury is the result of an Automobile accident or a Worker's Compensation claim please complete the following: **Date of Accident/Injury** _____ **State** _____ **Claim #** _____

b. Are you currently receiving any Home Health Services, or have you recently received Home Health Services for any condition? (i.e. Home Health Aide/Nurse/Therapy)? YES/ NO

Medicare will not pay for this Therapy if you have any medical person coming to your home for any reason.

c. Have you had any form of therapy this year, for ANY condition? YES/ NO If yes, when? _____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account and professional services rendered at Bay Area Physical Therapy, PA. I have read all the information on this sheet and have completed the above information.

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Patient Signature _____ Date _____ (Rev. 4/11)

Bay Area Physical Therapy & Wellness
Patient Medical Information

1. Are you (*circle one*): **Right-handed** **Left-handed**
2. Have you fallen in the last 12 months? **YES / NO**
3. If YES, were you injured in the fall? **YES / NO**
- *****Current Health Status (please circle yes or no):**
4. Do you smoke? **YES/NO**
5. Do you drink more than one alcoholic beverage per day? **YES/ NO**
6. Do you exercise regularly? **YES/ NO**
7. On average, how many days per week do you exercise? _____ For how long? _____
8. Leisure Activities/Hobbies

9. Are you pregnant? **YES/NO**
10. During the past month have you been feeling down, depressed or hopeless? **YES/NO**
11. Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? **YES/NO**

Please inform us if you have had a history of the following (put a check mark next to any that apply):

- | | |
|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Neurological Condition |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Rheumatic/Scarlet Fever |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Bowel/Bladder Dysfunction |
| <input type="checkbox"/> Hepatitis/ Jaundice | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Low Blood Sugar | <input type="checkbox"/> Urinary Tract Infection |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Hard of hearing |
| <input type="checkbox"/> Vision problems | |
| <input type="checkbox"/> Other _____ | |

Surgical/ Hospitalization History (please list any surgeries or hospital admissions you have had and when):

_____/_____/_____
 _____/_____/_____
 _____/_____/_____
 _____/_____/_____

CURRENT CONDITION(S)

CHIEF COMPLAINT(S)

- 1) Describe the problem(s) for which you seek therapy:

- 2) When did the problem(s) begin (date)? ____/____/____
- 3) What happened? _____
- 4) Describe activities you cannot do because of your problem _____
- 5) Have you ever had the problem(s) before? **YES/ NO**
- 6) (If Yes, answer a, b, c)
(a)What did you do for the problem(s)? _____

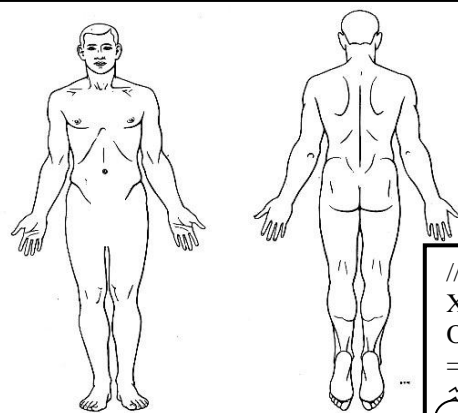
(b) Did the problem(s) get better? **YES/ NO**
(c) About how long did the problem(s) last? _____
- 7) How are you taking care of the problem(s) now?

- 8) What makes the problem(s) better?

- 9) What makes the problem(s) worse?

- 10) What are your goals for physical therapy?

Choose between 1 thru 10 for your pain level (**10 being worst**):
Today _____
Pain level at rest _____
Pain level with activity _____



Draw on the diagram using the key

- /// - Stabbing
- XXX - Burning
- OOO - Pins & Needles
- === - Numbness
- ~ - Throbbing
- (P) - Pain/Tender

Please check any of the following tests you have had for this problem:

- | | | |
|------------------------------------|---|---|
| <input type="checkbox"/> X-rays | <input type="checkbox"/> Blood Tests | <input type="checkbox"/> GI Tract Testing |
| <input type="checkbox"/> CT scan | <input type="checkbox"/> EMG | <input type="checkbox"/> EKG |
| <input type="checkbox"/> MRI | <input type="checkbox"/> Urine Culture | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Bone Scan | <input type="checkbox"/> Urodynamic Testing | |
| <input type="checkbox"/> DEXA Scan | <input type="checkbox"/> Laparoscope | |

Patient Signature/Guardian _____ **Age** _____ **Date** _____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information. (Revised 4/2011)



Bay Area Physical Therapy & Wellness

3637 Cortez Rd W Ste 103
Bradenton, FL 34210
941-739-7828
941-739-7838 fax

1401 8th Ave W Ste A
Palmetto, FL 34221
941-722-4000
941-722-4700 fax

Assignment of Insurance Benefits

If you are unable to keep your appointment, please inform the office **24 hrs in advance** to avoid any unnecessary charges. In an event that you do not attend and do not call for your appointment 2 times in succession you are subject to be discharged from our services; in which you and your physician will be notified.

We review our charges on a regular basis to ensure that they are fair and competitive. Bay Area Physical Therapy & Wellness PA is willing to file your primary and secondary insurances for any professional or medical service charges and will advise you of any problems that may occur. Bay Area Physical Therapy & Wellness PA provides the service of billing your insurance as a courtesy and will bill your claim at least once. Although, we will do what is necessary to recover benefits from your insurance company on behalf of services provided to you at Bay Area Physical Therapy & Wellness PA.

It is important to know that a verification of benefits is not a guarantee of payment from the insurance company.

I hereby instruct and direct my insurance company or companies to pay by check made out and mailed to:

Bay Area Physical Therapy & Wellness PA

3637 Cortez Rd W Ste 103
Bradenton, FL 34210
Tele: (941) 739-7828
Fax (941) 739-7838

for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered at Bay Area Physical Therapy & Wellness PA. This is a direct **assignment of my benefits** under my insurance policy. This will not exceed my account balance to the above-mentioned assignee, and I agree to promptly pay upon receipt, any statement for services rendered. Balances that remain unpaid after 30 days are subject to service charges not to exceed eighteen (18) percent per year. A photocopy of this assignment shall be considered as effective and valid as the original.

Patient /Guardian Signature

Date

BAPT representative Signature

Date

I agree, that in the event Bay Area Physical Therapy PA obtains legal representation (Attorney) to settle any financial challenges or disputes pertaining to my account balance with Bay Area Physical Therapy PA, I will be responsible for all legal fees and any collection agency fees incurred regarding my case 06/25/09



**Bay Area Physical Therapy & Wellness
Consent for Purposes of
Treatment and Healthcare Services including Private Healthcare
Information**

I authorize, Bay Area Physical Therapy & Wellness licensed clinical staff, by my signature on this document, to evaluate and treat my condition. I understand that treatment of my condition by Bay Area Physical Therapy & Wellness PA's licensed clinical staff is conditioned upon my verbal or written consent.

I consent to the use or disclosure of my protected healthcare information (PHI) by Bay Area Physical Therapy & Wellness PA for the purpose of providing treatment, payment for healthcare bills or to share PHI with those entities identified by me or by any written information identifying myself. I understand I have a right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment or sharing with identified entities. Bay Area Physical Therapy & Wellness PA in some circumstances is not required to adhere to the requested restrictions that I may request. However, if Bay Area Physical Therapy & Wellness PA agrees to a restriction in writing that I request, the restriction is binding on Bay Area Physical Therapy & Wellness PA and any employee of that entity.

My PHI includes demographic information, collected from me and created or received by my physicians, another healthcare provider, my healthcare plan, my employer or a clearing house. This PHI pertains to my past, present and future medical or mental conditions, and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that Bay Area Physical Therapy & Wellness PA will not be liable for any loss or damage to any money, documents, and other articles of value that I voluntarily choose to bring to the facility.

Bay Area Physical Therapy & Wellness PA will condition treatment upon the execution of this consent. I understand I have the right to review Bay Area Physical Therapy & Wellness PA's, notice of privacy practices prior to signing this consent and it will be provided to me upon request.

I certify that I have reviewed, understand and acknowledge the above consent.

Printed Name

Patient Signature/ Personal Representative

Date

Bay Area Physical Therapy & Wellness PA
Representative

Date

I have the right to revoke this consent, in writing, at any time, except to the extent that Bay Area Physical Therapy & Wellness PA has to take action regarding this consent. Revised 01/17/09

