Name: _____ DOB: ___/___/____ AGE:____ Marital Stat: M S W D

Address: _____City: _____ State: ____ Zip: _____

Phone: Home _____ Work_____ Mobile _____

Employer _____ Occupation: _____

Gender: M/F/O Height: _____Weight: _____

Emergency Contact: _____ phone: _____

Primary Care Physician: _____ Referring Physician: _____

Auto Accident (Yes/No) State Accident Occurred_____ Work Injury (Y/N)

If Workers Comp
__ Light Duty Due to Injury-since _____ Out of Work Due to Injury-since_____

Are you currently under the care of a Home Health Agency? Yes/No (If yes – PT is NOT covered)

Have you had any other physical, occupational, or speech therapy this calendar year including home health? Yes/No . If yes these visits may be counted towards your yearly visit allowance.

Employment Status
- o Full Time
- o Part Time
- o Retired
- o Not Employed
  Disabled

Student Status
- o Full Time
- o Part Time

PAST MEDICAL HISTORY: (*Circle any condition you have had or have*)

Cancer	Seizures/Epilepsy	Fibromyalgia	Other_____
High Blood Pressure	Parkinson Disease	Kidney Problems	_____
Osteoporosis	Multiple Sclerosis	Allergies/Asthma	HIV/AIDS
Thyroid Problems	Broken Bones	Diabetes I II	MRSA
Skin Disease	Liver Disease	Heart Problems	Infectious Disease
Head Injury	Arthritis	Stroke	
Lung Problems	Depression	Pace Maker/defibrillator	

PAST SURGICAL HISTORY _____

HOBBIES/ACTIVITIES _____

Are you: __ Right Handed __ Left Handed, Do you smoke? Yes/No # Packs/Day_____
Latex Allergies? Y/N Other Allergies_____ Are you Pregnant? Y/N Due Date_____

Current Medications: (include all OTC, herbs, vitamins) –Please provide a list if your Dr did not send.

Current Complaint _____
When did this issue start? _____
Was this an injury? Y/N
How were you injured _____
Surgery for this injury (Y/N) **Date of surgery** _____
What makes your symptoms better? _____

What makes your symptoms worse? _____

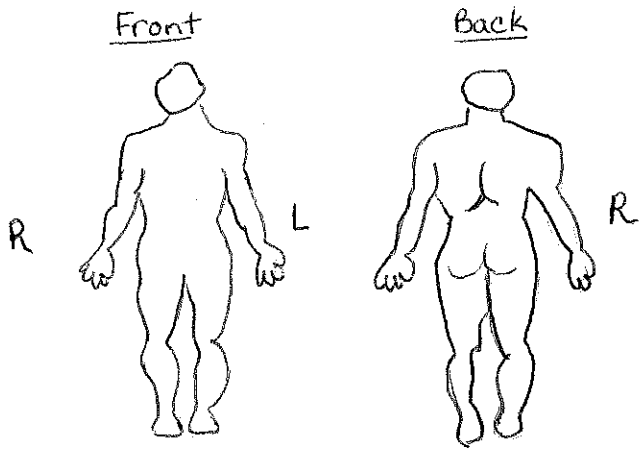
My symptoms are currently: ____ **getting better,** ____**about the same,** ____ **getting worse**

<u>What treatments have you received for this problem so far?</u>

Treatment	**Date**	**Result**
○ **X-Ray**	_____	_____
○ **MRI**	_____	_____
○ **CT Scan**	_____	_____
○ **PET Scan**	_____	_____
○ **Ultrasound**	_____	_____
○ **EMG/Nerve Conduction**	_____	_____
○ **Injections**		
○ **Surgery**		
○ **Accupuncture**		
○ **Chiropractic**		
○ **Medication**		
○ **PT**		
○ **Other** _____		

Indicate where your pain is located and what type of pain you feel at the present time. Use the symbols below to describe your pain . Do not include areas of pain which are not related to your present problem.

$$$$ **Dull/Achy**
//// **Stabbing**
XXXX **Burning**
0000 **Pins & Needles**
==== **Numbness**



<u>Pain Level 0=best, 10=worst</u>
Pain level at worst (0-10) _____ **Pain level at best (0-10)** _____ **Pain level now (0-10)** _____

What goals would you personally like to achieve as a result of your therapy?
1. _____
2. _____
3. _____

Date: _____ **Name:** _____**Signature :** _____

HIPPA PRIVACY

I acknowledge that I have been provided a copy of Bennington Physical Therapy's Privacy Practices.

AUTHORIZATION TO PAY BENEFITS TO BENNINGTON PHYSICAL THERAPY

I hereby authorize payment directly to Bennington Physical Therapy (BPT) for all medical benefits for services rendered. I understand that I am financially responsible for any and all charges NOT COVERED by my insurance. This includes Electrical Stimulation ($40), Ultrasound ($35), Iontophoresis ($40) and orthotics ($400). In addition, I will pay my co-insurance on a weekly or bi-weekly basis, as well as any deductible not met at the time of service, unless other arrangements are made.

HOME HEALTH

I am not being seen by any Home Health Agency. If I receive any Home Health care during my physical therapy I understand that outpatient Physical Therapy is not covered at the same time. If I do not advise the office and continue with physical therapy I agree to pay all charges that my insurance denies or recoups. (Even if you are discharged from Home Health some insurance plans count Home Health towards yearly allowable visits. Please check with your plan)

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize BPT to release any information acquired in the course or my examination and/or treatment to my insurance company, physician and employer (for Workers' compensation only).

AUTHORIZATION TO TREAT A MINOR

I hereby authorize BPT to render Physical Therapy to my child (under 18) as defined in my child's plan of care created by the PT.

PATIENT RESPONSIBILITY INFORMATION

All insurance policies are different and therefore everyone's coverage is different. It is your responsibility to find out how much your policy covers, both in terms of number of visits and cost. You are responsible for payment of anything insurance doesn't cover. Co-pays are due at the time of your visit or once a week as arranged. Any unpaid balances that go beyond 60 days will be assessed a $5 billing fee each month. Any bills sent to collections will be subject to a collection fee of $15. We do not sign liens for claims with your attorney. We do not take third party liability claims. Balance of bills not paid are your responsibility.

Your recovery is a team effort between you and your therapist. Your therapist will design a program for you based on your needs. This may include home exercise as well as an appointment at our facility. **In order to get the optimal results, you will need to follow through with your plan of care. At times scheduling with another therapist/therapy assistant may be necessary during the course of your treatment.** Despite the formality of the government Privacy practices, at BPT we strive to render therapy in a relaxed atmosphere. All or part of your treatment may take place in our large exercise room with patients and other therapists. Conversation and treatment will include using your name in this setting. We feel this atmosphere often fosters positive conversations of similar experiences. There are some treatments that do require more privacy and will be performed in a separate treatment room. If you have concerns about your treatment please talk to your therapist.

We would appreciate at least 24 hours' notice if you need to cancel your appointment. If you are more than 10 minutes late, we may need to reschedule you. LATE VISITS cause the Therapist to run behind and interfere with other patient's appointments. If you no-show twice any future appointments will be cancelled and we will not schedule appointments ahead of time. You must call the day you wish to be seen and we will accommodate you if possible.

Welcome to our practice! Thank-you for letting us aid in your rehabilitation!

I HAVE READ AND UNDERSTAND ALL OF THE ABOVE. I HAVE BEEN GIVEN AND READ THE MEDICARE CAP INFORMATION (MEDICARE PATIENTS ONLY)

Name: _____ Date: _____

Bennington Physical Therapy
MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your treatment with Bennington Physical Therapy. When you schedule an appointment with us we set aside enough time to provide you with the highest quality care. Should you need to cancel or rescheduled an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

*Effective August 1, 2018 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours notice will be considered a No Show and charged a $25.00 fee.

*Any established patient who fails to show or cancels/reschedules an appointment with no 24 hour notice a second time will be charged a $50.00 fee.

* If a third No Show or cancellation/reschedule with no 24 hour notice should occur the patient may be dismissed from our practice.

*Any new patient who fails to show for their initial visit will not be rescheduled.

* The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.

* As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee. You may contact Bennington Physical Therapy 24 hours a day, 7 days a week at the numbers below. Should it be after regular business hours Monday through Thursday, or a weekend, you may leave a message. 802-447-2101

Signature Date