



## Patient Information Sheet

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/20\_\_\_\_

Address: \_\_\_\_\_ Mailing Address: Same as Physical Address? ☐

\*SSN: \_\_\_\_\_

Email: \_\_\_\_\_ Appointment Reminders: ☐

Employer: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Home: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Do you have Aflac? Yes No

Reason you are here today: \_\_\_\_\_

Date your symptoms began: \_\_\_\_\_

Were you hospitalized for this injury: Yes No If yes, what dates: \_\_\_\_\_

Did you have surgery: Yes No If yes, what date: \_\_\_\_\_

Did you miss work for this injury: Yes No If yes, what dates: \_\_\_\_\_

Are you currently participating in Home Health Care? Yes No Discharge date: \_\_\_\_\_

Have you had PT for this condition? Yes No If yes, where: \_\_\_\_\_

**Is this due to a Motor Vehicle Accident?** Yes No If so, do you have a lawyer? Yes No

In what state did the motor vehicle accident occur? \_\_\_\_\_

**Circle ALL that apply:** MALE FEMALE SINGLE MARRIED WIDOWED DIVORCED

EMPLOYED UNEMPLOYED F/T Student P/T Student RETIRED DISABLED

### WORKMAN'S COMPENSATION

If you are a Workman's Comp patient, please fill out the following information:

Employer: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Company Address: \_\_\_\_\_

**If your insurance is NOT under your name please give information of insured person:**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ \*SS# \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Active Duty or Retired \_\_\_\_\_ Rank: \_\_\_\_\_

**\*FULL SSN OF SPONSOR IS REQUIRED FOR ALL TRICARE PATIENTS!**



## PAST MEDICAL HISTORY QUESTIONNAIRE

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Weight \_\_\_\_\_ lbs. Height \_\_\_\_\_ ft. \_\_\_\_\_ in. **(required for all Medicare patients)**

Please check all conditions **YOU** currently have or have had in the past

\_\_\_ Heart Attack/ Heart Surgery Year? \_\_\_\_\_ Please explain: \_\_\_\_\_

\_\_\_ Circulatory Problems. Please Explain: \_\_\_\_\_

\_\_\_ Congestive Heart Failure/ COPD

\_\_\_ Pacemaker

\_\_\_ Asthma, Shortness of Breath and/or Other Breathing Problems

\_\_\_ Seizures

\_\_\_ Stroke. When/side effected: \_\_\_\_\_

\_\_\_ Back or Neck Problems

Type of Problem \_\_\_\_\_

Surgeries and Dates \_\_\_\_\_

\_\_\_ Other Orthopedic Problems

Type of Problem \_\_\_\_\_

Surgeries and Dates \_\_\_\_\_

\_\_\_ Cancer

What Region \_\_\_\_\_

Dates of Occurrence \_\_\_\_\_

\_\_\_ Diabetes

\_\_\_ High Blood Pressure

\_\_\_ Degenerative Joint Disease/ Osteoarthritis

\_\_\_ Rheumatoid Arthritis

\_\_\_ Osteoporosis/ Bone Thinning

\_\_\_ Are you presently Pregnant? YES NO

\_\_\_ Surgeries and Dates not mentioned above \_\_\_\_\_

\_\_\_ Do you have any metal in your body (screws, plates, rods, etc)

If so, where \_\_\_\_\_

Latex or any other allergies? \_\_\_\_\_

Please list any related X-ray, CT scans or MRI tests taken and results: \_\_\_\_\_

Are you presently working? YES NO Last date worked: \_\_\_\_\_ Occupation: \_\_\_\_\_



What's your status?    FULL DUTY    LIGHT DUTY    Heaviest item lifted at work (pounds): \_\_\_\_\_

Please list **all medications** that you are currently taking, including those prescribed, vitamins, minerals and supplements:

[illegible]

Do you or your immediate family (BIOLOGICAL Mother, Father, Sister, Brother, Son, Daughter) have a history of any of the following:

	YES	NO	DETAILS
Depression/ Anxiety			
Systemic Disease (ie- Lupus)			
Cancer (if so, where)			
Diabetes			
Heart Disease/ Stroke			
Have YOU ever been abused?			
Do you feel unsafe in your home?			

Please circle all of the following you **CURRENTLY** have:

YES	NO	Unexplained weight loss/gain	YES	NO	Sexual Difficulties
YES	NO	Nausea, Vomiting	YES	NO	Frequent Urination
YES	NO	Dizziness, Lightheadedness	YES	NO	Blood in Urine or Stools
YES	NO	Excessive Fatigue	YES	NO	Recently Fallen
YES	NO	Excessive Weakness	YES	NO	Problems with Balance
YES	NO	Numbness, Tingling	YES	NO	Muscle/Joint Swelling
YES	NO	Tremors	YES	NO	Arm/Leg Swelling
YES	NO	Double Vision	YES	NO	Bruise Easily
YES	NO	Skin Rash	YES	NO	Stress at Home or Work

	YES	NO	DETAILS
Does your pain ease when you rest?			
Do your legs become weak when climbing stairs?			
Date of last childbirth? Vaginal or C-Section?			
Do you have aching or pain in your groin, hips or legs that increase with exercise or physical activity?			
Have you recently had an injection in a joint?			
Have you recently had a cut, scrape or open wound?			
Have you recently taken a long car, bus or plane trip?			
Have you recently been bedridden for any reason?			
Are you or have you ever been a smoker? How long?			
Do you have pain or urinate when you laugh, cough, sneeze or breathe?			
Have you ever had kidney or gall bladder stones?			
Have you recently performed any repetitive activity or rigorous physical training program?			



### Authorization for Treatment and Designated Individuals Authorization Form

I authorize Total Body Therapy & Wellness to provide physical therapy treatment and services to myself or the below named patient. **I understand that I am responsible for my physical therapy. I understand that it is my responsibility to inform the therapist if I am feeling pain or if I have any adverse reactions. Total Body Therapy & Wellness, and any of their staff, are not responsible for the activities I do at home or their effects on my condition.**

I also authorize the release of such information that may be necessary for my care via email, electronic or facsimile transmission. **I authorize my physician and insurance company(s) to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment.** I authorize any other individuals listed below to have the ability to inquire about my treatment, schedule, and change or cancel my appointments on my behalf.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ (Parent/Guardian must sign if patient is a minor)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I also assign Total Body Therapy and Wellness all payments for medical services rendered to the patient. I understand that as a courtesy, Total Body Therapy & Wellness will verify and file my health insurance; however, there is not a guarantee of payment and all services rendered are subject to approval from the insurance company. I understand that I am responsible for any amount not covered by the insurance company. I understand that I am responsible for knowing and meeting the requirements of my insurance plan.

Doctor's name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Insurance Company / Lawyer's Name: \_\_\_\_\_

### NOTICE OF PATIENT INFORMATION PRACTICES AND PRIVACY POLICY

I understand and acknowledge the receipt of Total Body Therapy and Wellness's Notice of Patient Information Practices and Private Policy.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ (Parent/Guardian must sign if patient is a minor)

### AUTHORIZATION TO USE MEDIA FOR ADVERTISEMENT PURPOSES

I authorize Total Body Therapy and Wellness and any of its workers to use media (photos, videos, etc.) for websites, advertisements, signs, social networks, etc.:

\_\_\_\_ Yes \_\_\_\_\_ No

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ (Parent/Guardian must sign if patient is a minor)



### CANCELLATION/ NO SHOW POLICY

**A 24 hour advanced notice is required of all patients if you are not able to keep your appointment.**

**First No Show:** This one is on us! You will not be charged the \$35 missed appointment fee. Instead, you will just receive a friendly reminder to please not miss any other appointments.

**Second No Show:** You will be charged a \$35 fee for the missed appointment if no notice is given. This fee is the patient's responsibility and is not billed to any insurance company. Payment will be due at your next appointment date.

**Third And Subsequent:** You will be charged a \$35 fee for the missed appointment if no notice is given as well as forfeiting any pre scheduled appointments. Appointments will then be rescheduled on a week to week basis.

We understand that emergency situations may arise that prevent a 24-hour notice. In such instances we request that the patient (or authorized representative for the patient) call as soon as possible to inform the office that you will need to miss or reschedule your appointment. These cases will be handled on an individual basis at the discretion of the treating therapist and/or front office staff as to whether the cancellation fee will apply.

If you are a Workman/s Comp patient, no cancellation fee will apply for missed appointments. However, your case manager and/or insurance carrier will be notified of cancelled or missed appointments.

**All patients:** I have **read, understand, and agree** to the above policy for missed appointments.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ (Parent/Guardian must sign if patient is a minor)

### **FAMILY INFORMATION (only if patient is under 18 years of age)**

Father's Name: \_\_\_\_\_

Father's Date of Birth: \_\_\_\_\_

Father's Employer: \_\_\_\_\_

Father's Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Mother's Date of Birth: \_\_\_\_\_

Mother's Employer: \_\_\_\_\_

Mother's Phone: \_\_\_\_\_



## Payment Policy

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Thank you for choosing us as your physical therapy provider. We are committed to providing you with quality and affordable health care. This payment policy addresses how Total Body Therapy & Wellness will charge you, based on your insurance or services received. Please read this policy, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care.
8. **Missed appointments.** Our policy is to charge for missed appointments not canceled within a reasonable amount of time of 24 hours. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

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Signature of patient or responsible party/Date



THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE READ IT CAREFULLY.

#### TOTAL BODY THERAPY AND WELLNESS'S LEGAL DUTY

Total Body Therapy and Wellness is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

#### USES AND DISCLOSURES OF HEALTH INFORMATION

Total Body Therapy and Wellness uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative and evaluating the quality of care that we provide. Some examples of uses of your personal health information may include, but are not limited to, the following: (1) Contacting you by telephone/mail/email and leaving a message if necessary to provide or obtain information regarding appointments, your treatment, your patient account, treatment alternatives or other health related benefits and services that we offer, and/or company news; (2) Obtaining information from your referral source in order to schedule an appointment and to verify/authorize insurance benefits; (3) Announcing your arrival to the therapist in an area where others may hear the information; (4) Calling out your name in the waiting area; (5) Treating you in an open area where conversations between you and your therapist may be overheard by other patients and staff; (6) Sharing information as needed with other health care providers involved in your care; (7) Performing quality assurance tasks such as chart review and outcome analysis; (8) Forwarding information to your insurance carrier in order to receive payment on claims (after obtaining your Medical Records Release and Insurance Assignment), and/or (9) Sharing information to insurers and other entities involved in your workers' compensation case as authorized by law.

Total Body Therapy and Wellness may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Total Body Therapy & Wellness's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release information for any reason, you may later revoke that authorization to stop future disclosures at any time.

#### PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment or administrative purposes except when specifically authorized by you, when required by law or in an emergency circumstance. Total Body Therapy & Wellness will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

#### CONCERNS AND COMPLAINTS

If you are concerned that Total Body Therapy & Wellness may have violated your privacy rights or if you disagree with any decision we have made regarding access or disclosure of your personal health information, please contact our Privacy/Security Office at the address below. You may also send a written complaint to the US Department of Health and Human Services. Total Body Therapy & Wellness will not tolerate any retaliatory acts against anyone who files a complaint. For further information on Total Body Therapy & Wellness health information practices, or if you have a complaint, contact the following person: Sara Morrison, Total Body Therapy & Wellness, 2 The Square at Lillington, Lillington, NC 27546, Phone: (910) 893-2850, Fax: (888) 867-7402.