CoreBalance Therapy LLC

Patient Information and Medical History

Name______________________________________ Date of birth_______________________________
Address____________________________________ City & Zip Code____________________________
Phone (hm) _________________________________ Social Security # __________________________
(wk/cell)_______________________________ Gender (please circle): Male Female
Are you (please circle): employed not employed Employer___________________________________
Marital status (please circle): M S D W
Are you (please circle): student non-student E-mail_____________________________________

Reason for visit____
Who referred you to this clinic / How did you hear about us? ____
Family member who has received care at this clinic? ____
When did you last see your primary care physician? ____
Date Today__________________ Date of injury *or* date symptoms began______________________________
If these symptoms or injury is related to an accident, was it (please circle): auto accident job-related other

Do you have, or have you had any of the following problems/diagnoses (please circle all that apply)?

chest pain	diabetes	sensitivity to cold
heart attack	surgery	urine leakage
pacemaker	metal implants	balance difficulties
fainting/dizziness	fractures	stroke
hypoglycemia	allergies	cancer

Please describe and date all of the selections you marked above. Also write any medications that you are taking; include birth control, vitamins and herbals.

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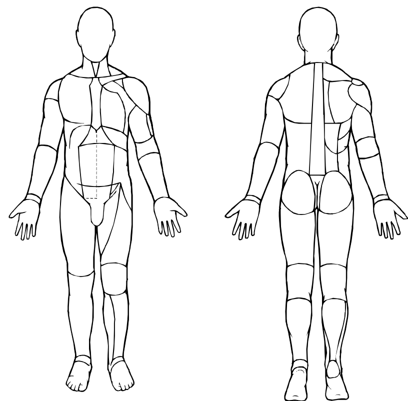

Please mark on the figure front and back where you have pain. Use the following marks to describe the type of pain you are having.

>>> means *sharp or lancing or stabbing*
+++ means *aching/throbbing*
èèè means *numbness or tingling*

On a scale of 0 to 10, 0 representing no pain, and 10 representing the worst pain possible, what number is your pain level:

at its worst? ______

at its best? _______

right now? _______

I understand that <u>I am responsible for payment of all physical therapy charges due CoreBalance Therapy LLC</u>. I understand that CoreBalance Therapy LLC will bill my insurance company for me. I authorize the release of any medical or other information necessary to process this claim. I request payment of insurance benefits to CoreBalance Therapy LLC.

Signed: ____ Date ___________________________

CoreBalance Therapy LLC.

Patient=s Acceptance of Conditions

1. COOPERATION WITH TREATMENT:
I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with the home program assigned to me. If I have difficulty completing my home therapy, I will discuss it with my therapist.

*Initial here*________

2. NO WARRANTY:
I understand the physical therapy provider does not promise a cure for my condition.
I understand that my therapist will share with me the available statistics and studies regarding results of physical therapy treatment for my condition. All treatment options will be discussed with me.

*Initial here*________

3. INFORMED CONSENT TO TREATMENT
I understand the term Ainformed consent@ means that the potential risks, benefits and alternatives of physical therapy treatment have been explained. I will receive information at the initial visit on the treatment/assessment options available for my condition. I will be included in making decisions regarding my care and will not be forced to participate in any procedure that I oppose.

*Initial here*________

Potential Risks:

I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury.
This discomfort is temporary and will probably subside in 24 hours.

*Initial here*_________

Potential Benefits:

These include an improvement in my symptoms and an increase in my ability to perform my daily activities.

may experience increased strength, awareness, flexibility and endurance in movement. I may experience decreased pain. I will have greater knowledge on managing my condition and the resources available to me.

*Initial here*_________

Alternatives:

All physical therapy treatment options available for my condition will be explained. I may inquire on the cost of these services and discuss them with my therapist. If I do not wish to participate in the program, I may discuss my medical, surgical or pharmacological alternatives with my physician.

*Initial here*_________

Based on the information I have received from the therapist, I voluntarily consent to physical therapy treatment. I understand that I may withdraw at any time.

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Patient Signature **Therapist Signature** **Date**

CoreBalance Therapy LLC.

Billing Practices:

1. INSURANCE BILILNG
   I understand and agree that CoreBalance Therapy will bill my health insurance company as a service to me, provided they are under contract with my particular insurance company. I am aware that reimbursement is dependent upon my particular plan with that company, including deductibles, contracted rates and allowed amounts. I understand that I am ultimately responsible for payment of services received at CoreBalance Therapy.

   *Initial here*______

2. INSURANCE BENEFITS
   I understand and agree that CoreBalance Therapy will attempt to acquire benefits information and required authorizations prior to my first visit and make the best attempt to inform me of the benefits. I should expect for the services provided at CoreBalance Therapy. I am aware that I am ultimately responsible for understanding my benefits as they are delineated in my contract with my health insurance company.

   *Initial here*______

3. APPOINTMENT CANCELLATIONS AND NO SHOWS
   I understand and agree that there is a 24-hour cancellation notice and no show policy. I understand and agree that I will be charged a $60.00 fee for ALL no shows and cancellations not given within 24 hours.

   *Initial here*______

4. PAYMENT PROGRAM
   I am aware that in individual circumstances, CoreBalance Therapy will accept monthly payments as determined and agreed upon by both parties.

   *Initial here*______

5. COLLECTIONS
   I understand and agree that CoreBalance Therapy utilizes the services of a collection agency and unpaid balances greater than 30 days past due will be considered for collections. I understand that I am responsible for all collection costs, in the event that my account is referred to a collection agency for non-payment.

   *Initial here*______

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Patient Signature **Therapist Signature** **Date**

PATIENT ACKNOWLEDGMENT OF RECEIPT OF PRIVACY INFORMATION

I have received the CoreBalance Therapy LLC Notice of Privacy Practices. This notice informs me of my privacy rights and the privacy practices of CoreBalance Therapy LLC.

Yes / No (please circle one)

I have declined receipt of the CoreBalance Therapy LLC Notice of Privacy Practices. This notice informs me of my privacy rights and the privacy practices of CoreBalance Therapy LLC. I understand I can request a copy of the Notice at any time.

Yes / No (please circle one)

____
PATIENT SIGNATURE

____
DATE