

Sports & Wellness Center
3124 North Swan Road

Orthopaedic & Joint Center
8327 North Oracle Road



BODYCENTRAL
Physical Therapy

Ultimate Sports Asylum
1991 East Ajo Way, Suite 149

Spine & Athlete Performance Center
7493 East Tanque Verde Road

Phone: (520) 325-4002 • Fax: (520) 325-4227 • www.BodycentralPT.net

PATIENT VERIFICATION/BENEFITS FORM

Your insurance company gave us the following information regarding your benefits:

Co-pay Amount per Visit: _____

Deductible Amount: _____

Co-insurance per Visit: _____

Based on the information your insurance company provided, we have calculated the amount you need to pay at each visit. Please note, if you have a deductible or a co-insurance, we are estimating the amount you will owe based on your insurance company's contract with our office. We will estimate this to the best of our ability, but please be aware that you may owe additional money.

Medical Supplies- cold packs, resistance bands, K-tape, pulleys, foam roller, and massage sticks are available for purchase with cash, check or credit card. Unfortunately, supplies are not covered by your insurance plan.

Please note that cancellations and no-shows are not covered by your insurance plan.

Estimated payment to be paid at each visit: _____

I understand that this is an estimated payment for services, and that I may be responsible for additional amounts based on my insurance payments and benefits. I understand that my benefits are determined by my insurance company and that Bodycentral Physical Therapy is not financially responsible for benefits that are not covered under my plan. If I overpay on my account, I understand that I will be refunded the overpayment amount directly and that I will receive this payment promptly within 30 days of my request for the refund.

Patient Name Printed: _____

Witness: _____

Signature _____ Date _____

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WELCOME TO OUR PRACTICE!

Please allow us to extend a warm welcome to you and thank you for choosing all of us at Bodycentral Physical Therapy to help you with your aches, pains and other things that bring you to us. There are a lot of choices for Physical Therapy in Tucson, and we do appreciate your business.

As an added bonus to coming to our practice, we provide a free Newsletter to all of our patients with tips on how to exercise correctly, healthy eating ideas as well as some recipes, and other great information on injury management and health. We also like to invite you to all our fun events and our community activities that we do throughout the year.

To sign up for this, all we need is your email address. We send a newsletter out twice a month—on the first and third Monday. If at any time you choose not to receive this newsletter, there is an opt-out button at the bottom. We also have a “share” button that you can use to send the newsletter to your friends or anyone else that might benefit from the information.

If you like our services, please feel free to share your experiences on Yelp.com, Facebook or any other online service you like.

If you have any issues or are not 100% satisfied with your experience with us, please tell us! We are happy to work with you to resolve any issues and make your time with us enjoyable. Therapy can be hard work, but there is absolutely no reason why you cannot have a little fun along the way. We are always looking for ways to improve, and your input is vital to that.

Yes! Sign me up for the newsletter. My email is:

No thanks, I do not want to sign up at this time.

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PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: ___ M/F _____

Address: _____ City/State/Zip: _____

Home Phone #: _____ Cell Phone #: _____ Email: _____

Date of Birth: _____ SSN#: _____ Referring Physician: _____

Primary Care Physician, if other than referring Physician: _____

Employer: _____ Occupation: _____ Work Phone: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

*******BILLING & INSURANCE INFORMATION*******

Primary Insurance: _____ Policy #: _____

Relationship to the Insured for Primary Insurance: Self Spouse Child Other: _____

Policy Holder Name: _____ DOB: _____

Secondary Insurance: _____ Policy #: _____

Relationship to the Insured for Secondary Insurance: Self Spouse Child Other: _____

Policy Holder Name: _____ DOB: _____

IF OTHER THAN ABOVE:

Related to Work Injury or Automobile: Yes or No _____ If Yes, Date of Injury: _____

Attorney Name: _____ Attorney Phone Number: _____

Claim #: _____ Auto – Do you have MedPay on Policy: _____

Are you presently receiving Home Health Care? _____ Name of Agency: _____

*******HIPAA*******

I have been offered a copy of the notice of privacy practices and have accepted or denied the offer. I give my consent that my health information can be used for the purpose of treatment, payment, and health care operations.

*******PAYMENT POLICY*******

I authorize payment to be made and/or sent directly to BODYCENTRAL Physical Therapy. I agree to be responsible for any unpaid balances for services rendered. I agree to pay my deductible and/or copayment upon each visit. I understand that obtaining any necessary insurance referrals from my referring physician is my responsibility. If the bill is sent to our collections agency, I further agree to pay the cost of collections. This includes all reasonable attorneys' fees for all unpaid bills submitted.

Signature _____ Date _____

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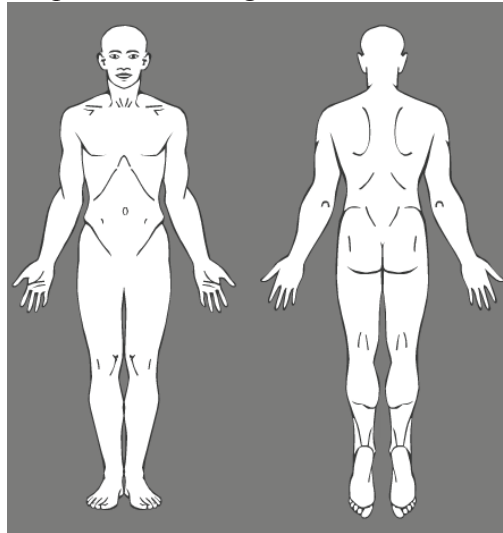
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PATIENT MEDICAL HISTORY

Please mark the location of your current pain on the diagram below:



Date of injury: _____

What caused your injury/symptoms? _____

Circle the word that describes your pain: Sharp Burning Aching Numbness Tingling Throbbing

What aggravates your pain:

What relieves your pain:

Rate Your Pain Below: 0=No pain 10=Extreme pain

At its worst in the past 3 days: 0 1 2 3 4 5 6 7 8 9 10

Right Now: 0 1 2 3 4 5 6 7 8 9 10

At its best in the past 3 days: 0 1 2 3 4 5 6 7 8 9 10

Have you had a fall in the last year? Yes No If yes, was there an injury? _____

What are your goals/expectations from physical therapy? _____

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PATIENT MEDICAL HISTORY

Do you have any of the following?

- Yes No Coronary Artery Disease
- Yes No Congestive Heart Failure
- Yes No High Blood Pressure
- Yes No Cancer/Type _____
- Yes No Diabetes Type I/II _____
- Yes No Blood Clot/Emboli
- Yes No Epilepsy/Seizures
- Yes No Thyroid Disease
- Yes No Kidney Disease
- Yes No Anemia
- Yes No Headaches
- Yes No Dizziness/Fainting
- Yes No Unexplained Weight Loss/Gain
- Yes No Stroke/TIA

- Yes No Osteoporosis/Osteopenia
- Yes No Infectious Disease
- Yes No Osteoarthritis
- Yes No Rheumatoid Arthritis
- Yes No Fibromyalgia
- Yes No Multiple Sclerosis
- Yes No Vision Changes
- Yes No Do you smoke?
- Yes No Are you pregnant? ___ weeks
- Yes No Do have a latex allergy?
- Yes No Do you have other allergies?
- Other: _____
- Height: _____ Weight: _____

PELVIC HEALTH (if applicable):

- Yes No Vaginal Delivery: # _____
- Yes No C-Section: # _____
- Yes No Episiotomy: # _____
- Yes No Prolapse or organ falling out
- Yes No Painful intercourse
- Yes No Trouble initiating urine stream
- Yes No Urinary or fecal leakage

- Yes No Pelvic Pain
- Yes No Painful periods
- Yes No Menopause: when? _____
- Yes No Recurrent bladder infections
- Yes No Constipation/straining
- Yes No Trouble feeling bowel urge
- Other: _____

Have you had surgery for this injury? Yes No If yes, date and type of surgery: _____

Other surgeries: _____

Diagnostic tests (Xray, MRI, Ultrasound, NCV, etc): _____

List of your current prescription and/or non-prescription medications (or bring in list):

Name	Frequency	Dosage	Route (oral, etc)

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CONDITIONS & CONSENT FOR PHYSICAL THERAPY

1. COOPERATION WITH TREATMENT:

I understand that in order for physical therapy to be effective I must attend scheduled appointments. I understand that I may be discharged from physical therapy if I do not attend two (2) appointments without calling to cancel or reschedule. I agree to cooperate with the home program assigned to me. If I have difficulty, I will discuss it with my therapist.

2. NO WARRANTY:

BODYCENTRAL Physical Therapy does not promise a cure for my condition. The staff will share with me the available statistics and studies regarding results of physical therapy treatment for my condition. They will discuss all treatment options with me.

3. INFORMED CONSENT TO TREATMENT:

The term “informed consent” means that the potential risks, benefits and alternatives of physical therapy treatment have been explained to you. BODYCENTRAL Physical Therapy provides a wide scope of services and you will receive information at the initial visit on the treatment/assessment options available for your condition.

A. Potential Risks:

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

B. Potential Benefits:

Benefits include an improvement in your symptoms and an increase in your ability to perform your daily activities. You may experience increased strength, awareness, flexibility and endurance in your movements. You may experience decreased pain and discomfort. You will have greater knowledge to manage your condition.

C. Alternatives:

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

I have read or had read to me the foregoing and any questions have been answered to my satisfaction. I understand the risks, benefits and alternatives of the treatment. I voluntarily consent to physical therapy treatment. I understand that I may withdraw at any time.

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CANCELLATIONS AND NO-SHOWS

We take this subject seriously at each clinic because it can make the difference in whether you succeed in treatment or not. Your doctor and/or therapist have prescribed a set frequency for treatment. Showing up as scheduled for these visits is your most important job.

- We require 24 hours notice in the event of a cancellation. It is your responsibility to have an alternative time in mind to ensure you attend the fully prescribed number of treatments that week.
- **There is a \$25 charge for cancellation without 24-hour notice.** This charge will not be covered by insurance, but will have to be paid by you personally.
- **There is a \$40 charge for no-show (\$25 if your insurance is AHCCCS, per ARS 36-2930.01)**
- These fees must be paid prior to beginning the next treatment session.

Initial: _____

APPOINTMENT SCHEDULING

Please make every attempt to be on time for your appointments. If you arrive less than 10 minutes late we will likely accommodate you but call to verify this. If you are running more than 10 minutes late we will likely reschedule your appointment to a different time but call us to see whether or not we can accommodate you. If you are ever waiting in the lobby for more than 10 minutes, please let the front desk staff know so that we can let the therapist know as soon as possible.

Please read and sign below:

- I hereby authorize BODYCENTRAL Physical Therapy to release my records to my referring physician, my primary care physician, and my insurance carrier to obtain payment for services that shall be rendered.
- I hereby authorize payment directly to the business office of BODYCENTRAL Physical Therapy, if any, otherwise payable to me for services.
- Co-payments/Coinsurance/Deductible payments are due at the time of services rendered.
- I understand that I am responsible for the charges not covered by insurance and for any missed appointments that are not cancelled 24 hours prior to the appointment. To the extent permitted by Arizona statute, I agree, in the event of nonpayment to assume the costs of interest, collection, and legal action.
- I hereby authorize my insurance carrier to release information regarding my coverage to BODYCENTRAL Physical Therapy. I authorize agents of any hospital, treatment center, or previous physician to furnish copies of any records of my medical history, services, or treatment.
- I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services given by BODYCENTRAL Physical Therapy. In the event my insurance carrier does not accept assignment of benefits, or if payments are made directly to my representative, or me I will endorse such payments to BODYCENTRAL Physical Therapy.
- This agreement/consent will remain in effect unless revoked by me in writing, signed by myself and by an authorized representative from BODYCENTRAL Physical Therapy.

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NON-PAYMENT ON ACCOUNT

Should collection proceedings or other legal action become necessary to collect to an overdue account, the patient or the patient's Responsible Party understands that BCPT has the right to disclose to an outside agency all relevant personal and account information necessary to disclose to collect payment for services rendered. The patient, or the patient's Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, interest, all court costs, Attorney fees, and all collection fees.

Signature _____ Date _____