PATIENT INTAKE FORM

Patient Name:_____ **Date:**_____

Date of Birth:_____ **Circle one: Male Female**

Current Street Address:_____

City:_____ **State:**_____ **Zip:**_____

Is this your Primary Billing Address: Yes No

Home Phone:_____ **Mobile:**_____

Email Address:_____

Referring Physician Name:_____**Phone:**_____

Primary Care Physician Name:_____ **Phone:**_____

Community/development where you reside:_____

How did you hear about us? (circle one)

Doctor **Word of Mouth** **Advertisement** **Internet Search** **Other**

If you circled Word of Mouth or Other please provide the name of the person who referred you or specify how you found us: _____

BCS Physical Therapy & Wellness
10151 Enterprise Center Blvd Suite 200 Boynton Beach, FL
33437 Phone: 561-208-1008

BILLING INFORMATION

Please be aware our staff is fully comprised of independent contractor workers (1099) and they only get paid when they see someone. Please keep in mind that cancellations and no-shows can negatively affect these workers. Thank you! Owner Brent C Stuart

Primary Insurance Information

Insurance Name:_____ **Subscriber Name:**_____

Member ID#_____ **Date of Birth:**_____

Relationship to

Subscriber:_____

Secondary Insurance Information

Insurance Name:_____ **Subscriber Name:**_____

Member ID#_____**Date of Birth:**_____

Relationship to Subscriber:_____

MEDICARE REGULATION DISCLOSURE

Medicare regulations require us to make you aware of our billing procedures and your financial responsibility. BCS Physical Therapy & Wellness accept Medicare Assignment for skilled physical and occupational therapy. Medicare will pay 80% of the reimbursable service charges. We will bill your co-insurance for the remaining 20%. If you do not have a secondary insurance or if your secondary insurance does not pay, we will bill you directly for the balance. I have received the policy statement, and have read and agree to the policies therein.

Patient Signature_____ Date_____

RELEASE OF PERSONAL HEALTH INFORMATION TO THIRD PARTY BILLING CO.

I authorize COY SERVICE, INC. Kim Coy can be reached via email at kimcoy.medbilling@gmail.com or 561-568-6815, a third-party billing company, to use and disclose my Personal Health Information for the purpose of processing my medical claims.

Patient Signature _____ Date_____

PATIENT EMERGENCY CONTACT CONSENT

I authorize BCS Physical Therapy & Wellness to communicate directly with the following individual in regards to my health care:

Emergency Contact Name _____ Relationship_____
Telephone_____

PATIENT TELEPHONE CONSENT

At BCS Physical Therapy & Wellness, we are required to call the patient to confirm scheduled appointments. This acknowledges that you authorize BCS Physical Therapy & Wellness to: (please initial)

Yes_____ No _____ Leave a detailed message with the party answering your telephone

Yes_____ No _____ Leave a detailed message on your answering machine or voicemail

PATIENT NAME:_____ DATE:_____

CLIENT CONSENT TO TREATMENT (Please Initial)

_____ I have stated all known medical conditions on the Patient Intake Form. I have consulted a medical doctor or licensed medical health care practitioner regarding any checked or described conditions. I realize it is solely my responsibility to keep BCS Physical Therapy & Wellness and the attending therapist updated on any changes in my physical health and I understand that BCS Physical Therapy & Wellness and the practitioner shall not be liable should I fail to do so.

_____ I understand that although skilled care will be provided throughout the treatment process, certain risks do apply. These risks include, but are not limited to, injury to muscles, tendons, bones; elevated heart rate, blood pressure and respiration rate. By signing this release, I hereby waive and release BCS Physical Therapy & Wellness and its therapists, from liability of injury excepting acts of negligence.

_____ I understand BCS Physical Therapy & Wellness is obligated to abide by the Health Insurance Portability and Accountability Act (HIPPA) and understand the notice and how it relates to my personal information. BCS Physical Therapy & Wellness is required to provide you with a copy of our Notice of Privacy Practices which states how we may disclose/use your health information. I acknowledge that I have received a copy of BCS Physical Therapy & Wellness Notice of Privacy Practices. If I wish my medical information be shared with another party, I must provide written permission with exact names included.

_____ I understand that I am financially responsible for all services rendered at BCS Physical Therapy & Wellness. All questions regarding fees should be asked prior to service. If my insurance changes, I am responsible for notifying BCS Physical Therapy & Wellness prior to my appointment, otherwise I will be responsible for the full payment of the visit. I understand that if my account balance is not paid in full, it may be forwarded to a collection agency. If any delinquent account balance is referred to a collection agency, I understand that I will be financially responsible for all costs relating to the collection of my debt.

_____ I understand that BCS Physical Therapy & Wellness reserves my appointment time and That a 24-hour notice of cancellation is required. We reserve the right to charge a $30 cancellation appointment fee the same day of the visit. The practice is aware that emergencies can arise but repeated cancellations can result in a charge.

PAST MEDICAL HISTORY FORM

Patient Name:_____Date:_____

Please Check Any Applicable Conditions Either Current or Personal History

____High/Low Blood Pressure ____Osteoporosis ____Spinal Stenosis ____Arthritis
____Chest Pain/Angina ____Cancer ____Diabetes ____Heart Disease ____Headaches
____Neuropathy ____Heart Attack ____Dizziness ____Herniated/Bulging Discs
____Pacemaker ____Memory Deficits ____Parkinson's Disease ____Kidney Disease
____Stroke/CVA ____Epilepsy ____TMJ ____Fever

Briefly explain and give approximate date for all checked conditions. Also, include any surgeries and approximate dates. Indicate below any additional past medical history which has not been listed.

_____

_____

Have you had any fall in the past year (circle): NO YES How many: _____ Please explain:

_____

_____

Current Medications (please indicate prescription and non-prescription)

Medication	Dosage	Frequency	Route of Administration	Reason for Taking

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