NEW PATIENT INTAKE FORM

PATIENT INFORMATION				
PATIENT'S FULL NAME (LAST, FIRST, MI)				
ADDRESS		CITY	STATE	ZIP
BIRTH SEX Male Female	SSN		DOB (MM/DD/YYYY)	
HOME PHONE	CELL PHONE		WORK PHONE	
EMAIL		HOW DID YOU HEAR ABOUT US?		
REFERRING PHYSICIAN	ADDRESS			PHONE
EMERGENCY CONTACT NAME		RELATION		PHONE
INJURY/ILLNESS INFORMATION				
DIAGNOSIS	DATE OF INJURY (MM/DD/YYYY)		DATE OF SURGERY (MM/DD/YYYY)	
NATURE OF INJURY/ILLNESS		TYPE OF INJURY ON THE JOB MOTOR VEHICLE OTHER		
PRIMARY INSURANCE INFORMATION				
PRIMARY INSURANCE COMPANY			PHONE NUMBER	
SUBSCRIBERS NAME		SUBSCRIBERS DOB (MM/DD/YYYY)		RELATION
ID#	GROUP ID#	EMPLOYER / PHONE		
INSURANCE ADDRESS				
SECONDARY INSURANCE INFORMATION				
SECONDARY INSURANCE COMPANY			PHONE NUMBER	
SUBSCRIBERS NAME		SUBSCRIBERS DOB (MM/DD/YYYY)		RELATION
ID#	GROUP ID#	EMPLOYER / PHONE		
INSURANCE ADDRESS				

I acknowledge that all the information that I have supplied on these forms is true, accurate, current, and complete.

_______________________________ _______________________________ _______________

Signature Printed Name Date

BODY MECHANIX REHABILITATION ESTD. 2012

Patient Medical History

Patient Name: ___________________________________ **Condition Begin Date** _____/ _____/ ______

Work Status: Full Time / Part Time / Off Duty **On the job injury?** Yes / No

Rate Your Pain (0 = No Pain, 10 = Worst Pain You Can Imagine)

Symptoms at Worst: ______ Symptoms at Best: _____Symptoms Today: _____

How much does pain limit activity? _________%

Current Medications (include ALL known prescriptions, over the counters, herbals and vitamin/mineral/dietary/nutritional supplements) ______**List Attached**

_____Not currently taking any prescribed or over the counter medications, herbals or vitamin/mineral/dietary (nutritional) supplements

Medication / Dose / Frequency / Method Medication / Dose / Frequency / Method

____________________/______/______/___________ __________________/______/______/_________

____________________/______/______/___________ __________________/______/______/_________

____________________/______/______/___________ __________________/______/______/_________

Past Surgical History

Type of Surgery Date Type of Surgery Date

______________________________ ____/____/ _____ ______________________________ ____/____/ _____

______________________________ ____/____/ _____ ______________________________ ____/____/ _____

Have you had any of the following diagnostic, medical, or rehabilitative services for this injury/episode?

Yes	No		Yes	No	
		Chiropractor			EMG/NCV
		Practitioner			Massage Therapy
		Neurologist			CT Scan
		Occupational Therapy			MRI
		Orthopedist			Myelogram
		Physical Therapy			Emergency Room
		Podiatrist			X-Rays

Past Medical History: Please check any condition you currently have OR have ever had in the past.

Yes	No		Yes	No	
		Asthma			Fibromyalgia
		Cancer			Pacemaker
		Diabetes			Heart Problems
		Blood Clot			Infectious Diseases
		Anemia			Sleep Problems
		Depression			Varicose Veins
		Anxiety			Osteoporosis
		Gout			Visual Dysfunction
		Seizures			Migraines/Headache
		Stroke			Pins or Metal Implants
		Concussion			Neurological Disorder
		Hernia			Rheumatoid Arthritis
		High Blood Pressure			Thyroid Trouble/Goiter

Allergies: ____

BODY MECHANIX REHABILITATION ESTD. 2012

Patient Medical History

Have you experienced any of these symptoms recently (please check all that apply)

Yes	No		Yes	No	
		Chest Pain			Pain with Meals
		Nausea/Vomiting			Dizziness
		Vision Changes			Memory Problems
		Unusual Weakness			Poor Balance/Falls
		Fever/Chills/Sweats			Difficulty Speaking
		Numbness/Tingling			Change in Appetite
		Difficulty Swallowing			Shortness of Breath
		Confusion/Brain Fog			Unexplained Weight Loss/Gain
		Increased Pain at Night/Rest			Change in Bowel Habits/Control
		Change in Bladder Habits/Control			Unusual Pain w/ Menstruation

Other(s) ____

Additional Information

Smoker Yes No If yes, packs per day

Alcohol Use Yes No If yes, drinks per day

Possibly Pregnant Yes No

By my signature below, I certify that the information I have provided above is complete, accurate and truthful to the best of my knowledge.

________________________ ________________________ ____________

Patient/Legal Guardian Signature **Printed Name** **Date**

New Patient Acknowledgements

Patient Name: ________________________________

Consent to Treatment

__________ Initial

I consent to and authorize Body Mechanix Rehabilitation to administrator rehabilitation therapy treatment. I understand and am informed that, as in the practice of medicine, rehabilitation therapy may have some risks. I understand that I have the right to ask about these risks and have any questions about my conditions answered prior to treatment. I know it is up to me to inform my provider of rehabilitation therapy about any health problems or allergies I have, as well as medications I am taking. I understand that the practice of rehabilitation therapy is not an exact discipline and I acknowledge that no guarantees have been made to me regarding treatment and/or treatment results from the rehabilitation therapy.

Notice of Privacy Practices

__________ Initial

I hereby acknowledge that I have been made aware of Body Mechanix Rehabilitation's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is available at the front desk and online, and that I may request a copy of any amended Notice of Privacy Practices at any time.

Authorization to Release / Obtain Information

__________ Initial

I hereby authorize the release of my patient health care information for the purposes of treatment or payment, to my physician, insurance company, adjustor, attorney, or other health care organizations pertinent to my case. Further, I authorize Body Mechanix to obtain needed information from my physician, insurance company, adjustor, attorney and any other health care organization pertinent to my case. These correspondence can be made via mailings, telephone and/or facsimile.

Insurance Eligibility

__________ Initial

Verification of benefits is NOT a guarantee of payment. Payment is determined by your insurance company at the time a claim is received. We provide you with the information as it is outlined by your insurance company. It is your responsibility to fully understand your insurance benefits.

Financial Responsibility

__________ Initial

It is the patient's responsibility to maintain all prescriptions, referrals and authorization as required by your insurance company. We will bill your insurance carrier as a courtesy to you. We have called your insurance carrier for the estimated insurance benefits, and they are as follows:________________________
____
____
____

Your *estimated* responsibility is: ____

__________ Initial

I have been advised that the providers at Body Mechanix Rehabilitation are not an "in-network provider" with my insurance plan therefore, services provided to me and billed by Body Mechanix Rehabilitation, will be considered "out-of-network" services.

I am responsible to forward ALL Checks sent to me by my insurance company to Body Mechanix Rehabilitation for the services provided by Body Mechanix Rehabilitation.

New Patient Acknowledgements

Assignment & Release of Benefits

___________ Initial

I hereby appoint Body Mechanix Rehabilitation as my authorized representative, and assign to it my right, to file for, receive and recover any and all monies payable for the care which it rendered to me from any third party claims payment source, including my health insurer, Medicare, Medicaid or other governmental program (collectively, my "Plan"), while I was eligible to receive such claim payment. I authorize you to send and receive documentation related to my treatment to, and consent to your discussing my treatment with, my Plan." I also authorize BMR to take any and all actions necessary to assert and pursue my legal rights to receive such claim payment under the terms of my Plan through any appeals and/or grievances and/or litigation and/or arbitration available to me for such purpose. As the assignor of the foregoing payment amounts, I direct that such payment be sent by my plan to BMR and, in the case that payment is made by my Plan to me, I agree to remit such payment in full to BMR not later than ten (10) days after my receipt.

General Conditions

___________ Initial

I acknowledge that I, the patient, am not permitted to utilize any rolling stool on the physical therapy floor unless specifically instructed by my clinician. Stools are only for staff members and BMR is not responsible for any injuries that occur from not abiding by this condition.

The undersigned patient or Responsible Party acknowledges that he/she has read and agrees to the information printed above.

______________________________	______________________	__________
Patient Signature (Parent/Guardian if patient under 18 years)	Printed Name	Date