



**PATIENT INFORMATION**

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

Name: \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_  
Last First MI

Are you a returning patient? Yes No SS# \_\_\_\_\_

Marital Status: (mark one) Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

Birthdate \_\_\_\_\_ Age: \_\_\_\_\_

Home Address \_\_\_\_\_  
Street Address City State Zip

Mailing Address (if different than home address) \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Primary Physician: \_\_\_\_\_

Referred by: \_\_\_\_\_

Emergency contact name: \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Primary Insurance Carrier: \_\_\_\_\_

Policyholder name: \_\_\_\_\_ Birthdate of policyholder: \_\_\_\_\_

Secondary Insurance Carrier:(if applicable): \_\_\_\_\_

Policy holder name: \_\_\_\_\_ Birthdate of policyholder: \_\_\_\_\_

**If under the age of 19 please list parents/legal guardian/guarantor (person responsible for bill):**

Father: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

Home phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Mother: \_\_\_\_\_ Date of Birth \_\_\_\_\_

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

Home phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

How did you hear about us? Physician Referral \_\_\_\_\_ Close to home/work \_\_\_\_\_ TV/Radio \_\_\_\_\_

Friends/Family \_\_\_\_\_ Other: \_\_\_\_\_



**PERSONAL HEALTH HISTORY- PAGE 2**

**MEDICATIONS**

What medications are you taking now? (Include prescription , over-the-counter drugs, supplements such as vitamins, and herbals.)

Medication name	Dosage	Frequency	Route of Administration (ie: oral, injection)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you fallen in the last year? Yes / No If yes, how many times in the last year? \_\_\_\_\_

If you have fallen in the last year, were you injured? Yes / No If yes, please explain \_\_\_\_\_

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1. CONSENT TO TREATMENT

I, knowing that I have a condition requiring diagnosis, treatment, or related, do hereby consent to such care, physical therapy examination, procedures, interventions, and/or treatment by physical therapists, their assistants/aides, as may be necessary in their professional judgment. I further acknowledge that no guarantees have been made to me as the results of such care, physical therapy examinations, procedures, and/or interventions. I also authorize the release of such information to the third party payor(s).

2. ASSIGNMENT OF BENEFITS

I hereby assign to Bussey Physical Therapy and to all therapists providing treatment(s) all right, title, and interest, in and to benefits payable affording clinic and therapist's coverage. I direct that such benefits be paid directly to said clinic and therapists.

3. INSURANCE PRE-CERTIFICATION INFORMATION

Many insurance companies have pre-certification requirements for physical therapy. If you are not sure whether your insurance company had pre-certification requirements, please check before evaluation/treatment so that you will not be denied insurance benefits for this visit.

4. AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Bussey Physical Therapy to furnish records from any treatments, photocopies of such records and/or information, and excerpts from such records to the attending physician, his/her associates, and/or consultants, and third party payor (whether an insurance company, government agency, or self-insured employer) and/or any transferee health care facility and/or agency for the purposes of obtaining payment for services rendered while under clinic care, performing utilization review, and/or post care treatment. If this is a work-related injury, I authorize Bussey Physical Therapy to provide my employer with any and all needed information related to my condition. Finally, if further care from another therapist, physician, or specialist were needed I authorize the release of my records to such a party.

**THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, AND IS THE PATIENT, OR IS DULY AUTHORIZED BY OR IN BEHALF OF THE PATIENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.**

*Authorization and Release*

*I certify that the information provided on all forms is true and correct to the best of my knowledge and behalf.*

*I authorize this clinic to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or health practitioners. I authorize my insurance company to pay directly to the physical therapy clinic's office, insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I understand I am responsible for all co-pays, deductibles, co-insurances and balances. I personally agree to pay for any and all services provided to me at the rates in effect during the time services are rendered. I understand and agree that my bill for services rendered is due and payable at the time of service and that I am ultimately responsible for any unpaid balances. A wide variety of means for communication exists and continues to broaden and develop. By signing this authorization, I agree that this office, and any third party used for treatment, billing, collection and other services, may use any means of communication with me. Thus, I understand and agree to any phone numbers and email addresses provided by myself to this office and to any of our service providers, now and in the future, may be used as a means to contact me, and that this office and our service providers may leave messages for me manually and by using automated systems such as by artificial or prerecorded voice. Specifically, if I provide a cellular phone number, I consent and agree to accept collection calls and other communications to my cellular phone from this office and from our service providers. For any landline and cellular phone calls this office or any service providers place to me, I consent and agree that those calls may be automatically dialed and that this office and our service providers may use recorded messages. I also agree that this office and any service providers may contact me by sending text messages and emails to any phone number or email address I provide to this office or service providers, and I consent to receive such text messages and emails which may identify the name of this office or service provider sending the communication, and may disclose the nature of the communication.*

X \_\_\_\_\_  
Signature of Patient/Responsible Party/Insured

X \_\_\_\_\_  
Signature of Witness

X \_\_\_\_\_  
Date and Time



**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**This form serves as an acknowledgement that you have received a copy of Bussey Physical Therapy LLC's Notice of Privacy Practices.**

**Please fill out the lines below and return to the receptionist at the front desk. Thank you.**

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

**Printed Name:** \_\_\_\_\_

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