



BRIDGE PHYSICAL THERAPY

New Patient Information (Please Print Clearly)

Patient Name: _____ Sex: Male ___ Female ___
Last First M.I.

Address: _____
Street City State ZIP

Email: _____@_____ Date of Birth: ____/____/____

Home/Mobile Phone: (____) ____ - _____ Work Phone: (____) ____ - _____ Ext. _____

Parent or Guardian (If Patient is a minor): _____

Is patient employed? Yes ___ No ___ Full-time student ____ Occupation: _____

Employer or School: _____ Marital Status: Married ___ Single ___ Other ___

Referring Dr: _____ Phone: (____) ____ - _____

Primary Care Physician: _____ Phone: (____) ____ - _____

How did you hear about our office: Website ___ Internet ___ Sign ___ Friend (Who can we thank?) _____ Other _____

Emergency Contact: _____ Phone: (____) ____ - _____

Insurance Information

Primary Insurance Co: _____ Policy ID#: _____

Name of Insured: _____ DOB: ____/____/____ Group ID #: _____

Secondary Insurance Co: _____ Policy ID#: _____

Name of Insured: _____ DOB: ____/____/____ Group ID #: _____

Is your injury work related? Yes ___ No ___ Is your injury related to an auto accident? Yes ___ No ___

If your injury is Work Related or an Auto Injury, please complete the following:

Employer at time of Injury: _____ Date of Injury: ____/____/____

Employer City, State, Zip: _____ Employer Phone #: (____) ____ - _____

Insurance Name: _____ Claim #: _____

Name of Adjuster: _____ Adjuster Phone #: (____) ____ - _____

Health Information

Date of onset of pain or injury: ___/___/___ Height: _____ Weight: _____

How were you injured: _____

Surgeries Performed and Dates (if applicable): _____

Pregnant or possibly pregnant (if applicable): Yes ___ No ___ Do you smoke or use tobacco: Yes ___ No ___

Do you have a history of falls? Yes ___ No ___ If Yes, when was your last fall: _____

Have you had any diagnostic testing? (Ex. X-ray, CT Scan, MRI, etc.). If so, what are the specific findings/results?

Current Medications: _____

What are your Physical Therapy goals? _____

Medical History:

- | | | |
|---|---|--|
| <input type="radio"/> No previous medical history | <input type="radio"/> Diabetes Mellitus type 1 | <input type="radio"/> Previous Physical Therapy |
| <input type="radio"/> Arthritis - Rheumatoid or OA | <input type="radio"/> Diabetes Mellitus type 2 | <input type="radio"/> Psycho-Social (depression, etc.) |
| <input type="radio"/> Cardiovascular /heart disease | <input type="radio"/> Allergies (food or other) | <input type="radio"/> Night pain |
| <input type="radio"/> Unexplained weight loss/gain | <input type="radio"/> Surgical history | <input type="radio"/> Cancer |
| <input type="radio"/> Bowel/Bladder changes | <input type="radio"/> Osteoporosis/Osteopenia | <input type="radio"/> Seizures |
| <input type="radio"/> Immune Deficiency disease | <input type="radio"/> Dizzy Spells | <input type="radio"/> Pacemaker/Implant of any kind |
| | | <input type="radio"/> Other |

Please describe: _____

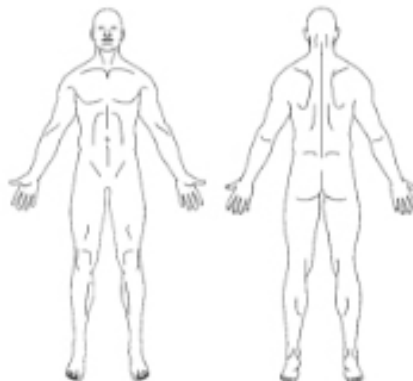
Which of the following functional activities do you have difficulty with due to condition/pain?

- | | |
|---|--|
| <input type="radio"/> Sleep | <input type="radio"/> Sitting/standing |
| <input type="radio"/> Self-care activities (i.e. dressing/bathing etc.) | <input type="radio"/> Bending/squatting |
| <input type="radio"/> Activities of daily living | <input type="radio"/> Mobility/walking/stairs (ascending/descending) |
| <input type="radio"/> Pushing/pulling/reaching | <input type="radio"/> Activities outside your home |
| <input type="radio"/> Lifting/carrying | <input type="radio"/> Other: _____ |

Which of the following make your pain better?

- | | |
|--|---|
| <input type="radio"/> Sitting | <input type="radio"/> Sit to stand |
| <input type="radio"/> Standing | <input type="radio"/> Bending |
| <input type="radio"/> Walking | <input type="radio"/> Laying down/elevating |
| <input type="radio"/> Medication or topical pain cream | <input type="radio"/> Ice or Heat |
| <input type="radio"/> Resting | <input type="radio"/> Other: _____ |

Please mark the body diagram where you feel current symptoms of pain with an "x". Mark with an "o" if numbness/tingling/pins symptoms are present on the following figures



: PLOF _____



Policies and Patient Consent and Release
BRIDGE PHYSICAL THERAPY LLC

Treatment Plan Policy:

Thank you for choosing Bridge Physical Therapy for your physical therapy needs. Our vision is to EDUCATE, EMPOWER and ELEVATE people to achieve their highest goals and BRIDGE THE GAP of functional limitations. We believe in a customized approach to physical therapy, as no two people are the same. Treatments are individualized to be concise, meaningful, and restorative.

To attain the best possible outcome from your physical therapy treatment plan, it is imperative that you attend all scheduled physical therapy sessions and put in your best effort. Please be aware that your pain may change as you progress through your treatment plan. If you experience more pain, it is critical for you to come in for your scheduled appointment. If your pain is decreasing, it is still important to continue with your established treatment plan to avoid future problems from the injury.

Financial Policy:

As a courtesy, we will bill the primary insurance company for our patients if we are provided the necessary information. Your insurance is a contract between you, your employer (if applicable) and your insurance company. We are not a party to that contract. Therefore, it is the patient's responsibility to determine what their insurance company allows for therapy, obtain prior approval (if necessary) and follow up with their insurance company on all unpaid visits. **Co-Payments are due at the beginning of each visit.**

Should your insurance deny payment or coverage for any reason, you are responsible for any and all charges billed.

Cancellation Policy: We require 24 hours advance notice for any cancellation. If you are unable to give the 24 hour advance notice or if you do not show for your scheduled appointment, an administrative fee of \$25 will be billed to you.

Acknowledgement of Receipt of Notice of Privacy Practices: By my signature below, I acknowledge that I received a copy of the Notice of Privacy Practices for Bridge Physical Therapy LLC.

Patient Consent and Release: I understand that I am financially responsible for all charges for service rendered regardless of litigation, insurance reimbursement or pending Loss and Injury claims. I understand the parent accompanying the minor for treatment will be responsible for payment. I request and consent to the performance of evaluation, treatment and procedures. I understand I am free to withdraw my consent and that I may stop treatment or any procedure at any time.

I authorize Bridge Physical Therapy LLC to release any necessary information requested by my insurance carrier and authorize payment directly to Bridge Physical Therapy LLC for any benefits available under my insurance plan.

I authorize treatment of the patient named on these Intake Forms and agree to pay all fees and charges for such treatment. I acknowledge, upon request, a receipt of a copy of this agreement. I agree to the terms stated on the following form regarding collection fees and charges. I agree to pay attorney fees and court costs, and any finance or interest charges, and an additional 33.33% collection fee of account balance if turned over to a collection agency in addition to the account balance.

Signature of Patient or Representative

Date

*If this acknowledgement is signed by a personal representative on behalf of the patient, then please complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

This form will be retained in your medical record.