Body Elite Physical Therapy Inc
3052 Valley Ave Suite 101
Winchester, VA 22601
(540) 535-7222 | (540) 254-5302 (fax)

Registration Information

Patient Information (Please Print)									
Patient's Name									
Responsible Party Name		Relationship to Patient							
Address									
City		State		Zip					
Home Phone #		Cell Phone #		Work Phone #					
Email Address									
Are you interested in receiving important health related information via e-mail?						Yes	❑	No	❑
Would you like to receive appointment reminders by email?	Yes	❑	No	❑	By text?	Yes	❑	No	❑
Gender		Age		DOB					
Marital Status	❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced								
Student Status	❑ Not a Student ❑ Full time ❑ Part time								
How did you hear about us?									
❑ Physician ❑ Family ❑ Friend ❑ Internet ❑ Ins. Company ❑ Other:									
Spouse's Information (or responsible party)									
Name									
Employer									
Address									
City		State		Zip					
Home Phone #		Cell Phone #		Work Phone #					
Emergency Information									
Name of nearest relative not living with you									
Home Phone #		Cell Phone #		Work Phone #					

Primary Insurance Information			
Company Name			
Address			
City		State	Zip
Phone #		Fax #	
Subscriber ID		Group #	
Relationship to Insured	❑ Self ❑ Spouse ❑ Child ❑ Unknown ❑ Other:		

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Secondary Insurance Information					
Company Name					
Address					
City		State		Zip	
Phone #		Fax #			
Subscriber ID		Group #			
Relationship to Insured	❑ Self ❑ Spouse ❑ Child ❑ Unknown ❑ Other:				

History (write on back if extra space is needed)			
Why are you being seen today?			
Date of onset of treatment need		Date of surgery	
Date of last physician visit		Date of Accident	
What other health care providers are you currently seeing or have seen within the last 2 years?			
Are you allergic to anything?			

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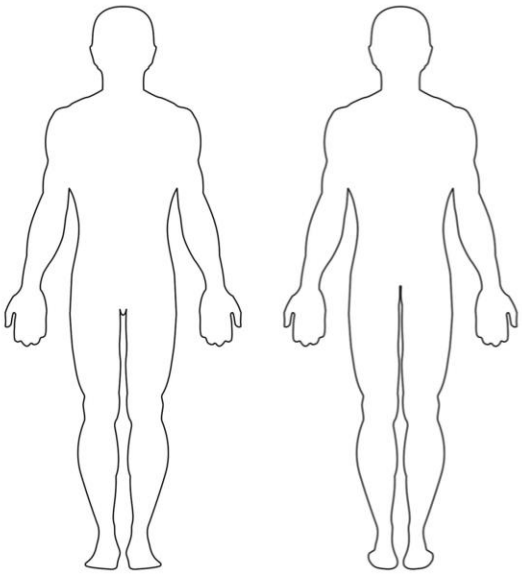
Body Elite Physical Therapy
Patient Questionnaire

1. What is the goal you hope to achieve with physical therapy and why?

2. Where is your pain? Please mark on the drawings below the area(s) where you feel you pain.

FRONT **BACK**



3. Pain Scale. Please mark your pain on the line below.

(No pain) ____1 _____ 2 ____ 3 ____ 4 ____5 ____6 ____7 ____8 ____9 ____10 (Max pain)

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Patient History

Name: _____ Date: _____

Do you have a history of high blood pressure?	❑ Yes	❑ No
Do you have a history of heart problems?	❑ Yes	❑ No
Do you have a pacemaker implant?	❑ Yes	❑ No
Do you have any metal implants (pins, plates, screws, IUD)?	❑ Yes	❑ No
Do you have any sensory impairment?	❑ Yes	❑ No
Are you pregnant?	❑ Yes	❑ No
Do you have any history of diabetes?	❑ Yes	❑ No
Do you have any history of cancer?	❑ Yes	❑ No
Do you have any history of circulatory problems?	❑ Yes	❑ No
Do you have any history of seizures?	❑ Yes	❑ No
Do you have any history of broken bones?	❑ Yes	❑ No
Do you have any history of head injury?	❑ Yes	❑ No
Do you have any history of stroke?	❑ Yes	❑ No
Do you have any vision/hearing problems?	❑ Yes	❑ No

Specify
_____

_____

Do you have any history of any type of hepatitis?	❑ Yes	❑ No
Have you had any unintended weight loss recently?	❑ Yes	❑ No
Are you currently taking any medications?	❑ Yes	❑ No

Please list any medications you are currently taking. _____

_____

Please list any surgeries you have had in the past. _____

_____

Have you ever had therapy before? ❑ Yes ❑ No

Is there anything else in your medical history you think we should know? _____

_____

_____

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Body Elite Physical Therapy Policies

Welcome to our practice. Please take a few minutes to read our policies.

Cancellation Policy: If you are unable to keep your appointment, kindly give us a **24-hour notice**. We reserve the right to charge **$50.00** for late cancellations no shows. After **2 no-shows** without any explanation, we will remove you from our schedule and you will be responsible for the fees. We only schedule one patient per hour, so someone else could benefit from your missed appointment.

Automobile Insurance (personal injury protection coverage): In order to submit a claim on your behalf to your automobile insurance company or your PIP coverage, we need the following information: Policy Number, Claim Number, Carrier's Name and Address, Date of Accident, Agent's Name and Telephone Number. **We can also submit your claims to your Health Insurance Company.**

Legal Cases: Although you may be represented by an attorney in a personal injury claim, this does not relieve you of your responsibility for timely payment. Because of the longevity of most legal cases, we cannot wait for settlement for payment of our fees. In all cases, payment is due when services are rendered.

Workman's Compensation: You will be billed for any charges determined not to be work related or denied by the insurance carrier, as well as any **late cancellation or no-show fees**. In order to submit your Workman's Compensation Injury, we need the following information:

Date of Injury, Claim Number, Case Manager Name and Number, Workman's Compensation Carrier Name, Address, and Telephone Number.

I authorize Body Elite Physical Therapy, Inc. to provide treatment to myself and / or below named patient. I authorize the release of any information required to process my claims to my insurance carrier(s) by Body Elite Physical Therapy, Inc. I also authorized my insurance benefits be paid directly to Body Elite Physical Therapy, Inc. I understand that I am financially responsible for any balance after insurance has made payment. If payment is not provided in a timely manner, in addition to the cost of your service, you will be charged an additional 35% to cover the cost of attorney, collection, and/or any other legal fees pertaining to your account.

I have read and agree to the above.

Patient Name: _____

Patient Signature _____ Date _____

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Health Insurance Portability and Accountability Act Statement

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used in the below circumstances.

I understand and give authorization to Body Elite Physical Therapy to make telephone calls to my home about my health-related information and appointment reminders. A message may be left on my answering machine/voice mail.

I understand that a letter may be sent to my primary physician and other healthcare providers (i.e. chiropractor, dentist, massage therapist, OBGYN, surgeon, acupuncturist, other medical specialist) that I see for medical care informing him/her that I am currently having therapy. If he/she requests updates on my progress, I am giving authorization to Body Elite Physical Therapy to send him/her copies of my progress reports that are also being sent to the referring physician. Please list below any EXCEPTIONS for providers that you do not authorize us to contact:

_____

_____

I hereby give my permission for authorized personnel of Body Elite Physical Therapy to perform all necessary procedures and treatments outlined in the plan of treatment.

I hereby authorize a representative of Body Elite Physical Therapy to be permitted to obtain and review copies of all hospital, medical, vocational, and other related records and to discuss pertinent information with professionals involved in my case.

EXCEPTIONS: (Please list) _____

In specific instances I also authorize Body Elite Physical Therapy to share information regarding my rehabilitation to/from my employer. I understand that the information shared will be used to assist in tailoring my rehabilitation program to my specific job tasks. If applicable, name of employer/contact information: ____

This consent is to remain in effect until otherwise revoked by me in writing. I agree that a photocopy of this authorization be accepted if necessary.

I have read and understand the above as well as the privacy notice provided to me by **Body Elite Physical Therapy.**

Patient Name: _____

Signature: _____ Date: _____