Welcome to Boost Physical Therapy

Please take a few minutes to provide the following information so we can provide you the best experience possible.

Today's Date: _____

Patient Information

Last Name: _____ First Name: _____ Middle Name/Initial: _____

Physical Address: _____ City: _____ State: _____ Zip Code: _____

Mailing Address: Check box if same as above ☐ _____

Home Phone #: _____ Cell Phone #: _____ Email Address: _____

Date of Birth: _____ Age: _____ Social Security #: _____

(Circle one) Single Married (*Circle one)* Male Female Employer:_____

If Patient is minor, name of Parent or Guardian: _____ Phone number(s)_____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

Returning Patient? *(Circle one)* Yes No Appointment Reminders: *(Circle one)* Text Call

Primary Care Physician: _____ Referring Doctor: _____

Person Responsible for Account (If different from patient)

Person Responsible for Account: _____ Relationship: _____

Physical Address: _____ City: _____ State: _____ Zip Code: _____

Mailing Address: Check box if same as above ☐ _____

Date of Birth: _____ Social Security #: _____ Phone Number: _____

Insurance Information *Please ensure that we get a copy of your insurance card(s)*

Primary Insurance Company: _____ Insurance Phone #: _____

Group #: _____ Policy #: _____ Driver's License #: _____

Policy Holders Name: _____ Social Security #: _____

Date of Birth: _____ Patient's Relationship to Insured: *(Circle one)* Self Spouse Child Other

Secondary Insurance Company: _____ Insurance Phone #: _____

Group #: _____ Policy #: _____ Driver's License #: _____

Policy Holders Name: _____ Social Security #: _____

Date of Birth: _____ Patient's Relationship to Insured: (Circle one) Self Spouse Child Other

Please continue to additional pages ➡

BOOST PHYSICAL THERAPY
Spine - Orthopedics

Medical History

Past	Present		Past	Present		Past	Present	
☐	☐	High Blood Pressure	☐	☐	Systemic Lupus	☐	☐	Joint Replacement
☐	☐	Angina	☐	☐	Hepatitis	☐	☐	Heart Disease
☐	☐	Heart Attack	☐	☐	Epilepsy	☐	☐	Kidney Disease
☐	☐	Stroke (CVA)	☐	☐	Diabetes	☐	☐	Emphysema/Bronchitis
☐	☐	Asthma/Lung Problems	☐	☐	Rheumatoid Arthritis	☐	☐	Depression
☐	☐	HIV/AIDS	☐	☐	Arthritis	☐	☐	Tuberculosis
☐	☐	Cancer /Tumor (Location: _____)	☐	☐	Pregnancy	☐	☐	Allergies
☐	☐	Headaches	☐	☐	Pacemaker	☐	☐	Tobacco (Pack/Day: __)
☐	☐	Fracture or Suspected Fracture	☐	☐	Obesity	☐	☐	Fibromyalgia
☐	☐	Dizziness/Blackouts	☐	☐	Nerve disorders	☐	☐	Visual problems
☐	☐	Traumatic Brain Injury	☐	☐	Cauda Equina Syndrome	☐	☐	Current infection _____

Reason for Treatment

Related Cause: (Circle one)

Auto Accident Fall Employment Injury Sports Injury Surgery Other Accident None of the Above

Date of Injury/first symptom: _____How did injury occur/symptom(s) begin? _____

_____

What activities INCREASE pain/discomfort? _____

What activities DECREASE the pain/discomfort? _____

How long have you had this pain/discomfort? ___Years ___ Months___ Weeks

Was the onset of your pain/discomfort Sudden_____ Gradual _____?

Are you currently taking any medications? ____No ____Yes: _____

Have you had any imaging performed? Yes/No: MRI_____ X-Ray _____ CAT scan_____

Date and Where imaging was performed? _____

Have you had surgery related to this problem? Yes/No: _____ Date: _____ What: _____

Have you had other surgeries? Yes/No: _____ Date: _____ What: _____

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Treatment Consent

I give my consent for Boost Physical Therapy to provide physical therapy treatment to _____

(Patient's Name)

I understand medical information about me will be disclosed to health care professionals, and my insurance company(s) for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct health care treatment at Boost Physical Therapy. I authorize assignment of benefits to Boost Physical Therapy. I do hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third-party payers to Boost Physical Therapy. I do hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment. I understand that I am responsible for my payment amount. Co-pays, deductibles, and cash pay agreements are due at the time of service. We bill your insurance carrier solely as a courtesy to you. I understand that I am responsible for any amount of my bill that is not covered by my insurance.

Patient/Responsible Party Signature: _____ Date: _____

Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW CAREFULLY:

Boost Physical Therapy is required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA) to provide confidentiality for all medical health records and other individually identifiable health information in their possession. This Notice is to inform you of the uses and disclosures of confidential information that may be made by Boost Physical Therapy, and of your individual rights and Boost Physical Therapy's legal duties with respect to confidential information.

Ways in which Boost Physical Therapy may use and disclose your protected Health information:

Boost Physical Therapy may use and disclose your medical records for each of the following purposes only: **treatment, payment and health care operations.**

- Treatment means providing, coordinating or managing health care and related services.
- Payment means activities such as obtaining payment for the health care services provided for you from your insurance or another third-party payer.
- Health care operations include the business aspects of running a practice.

Please continue to additional pages ➡

Boost Physical Therapy may contact you to provide appointment reminders or other services that may be of interest to you. Boost Physical Therapy may disclose your protected health information to any person you identify that is involved in payment for your care.

Boost Physical Therapy will use and disclose your protected health information when required by federal, state or local law. There are certain situations in which we are required by ethical standards to reveal information obtained during therapy to persons or agencies even if you do not give permission. These situations are as follows: (a) If you threaten grave bodily harm or death to yourself or another person, we are required by ethical standards to inform the intended victim and/or appropriate law enforcement agencies; (b) if you report your knowledge of physical or sexual abuse of a minor child or of an elder (over 65) or any sexual conduct/contact with a minor, we are required by law to inform the appropriate child welfare or social agency which may then investigate the matter; (c) if we are required by a court of law (court order) to turn over records to the court or if we are ordered to testify regarding those records.

Any other uses and disclosures will be made only with your written authorization. You will be provided with an authorization form upon request. A separate form will be needed for each request for release of information. The authorization for release of records is valid until it expires or is revoked. You may revoke authorization in writing. Boost Physical Therapy is required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

HIPAA Individual Acknowledgement of Privacy Practices

By signing this form, I am indicating that I have been provided a copy of Boost Physical Therapy's Privacy Practices containing a description of the uses and disclosures of my health information. I understand that this Notice is subject to change, and I can obtain a current notice by contacting this office.

Patient/Responsible Party Name: _____

Signature: _____

Date: _____