BROOKLYN BODY WORKS PHYSICAL THERAPY, P.C.
SPORTS & ORTHOPEDIC REHABILITATION

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME

ADDRESS	APT	CITY	STATE	ZIP CODE

HOME PHONE	CELL PHONE	WORK PHONE

DATE OF BIRTH	SEX	SOCIAL SECURITY #
	☐ FEMALE ☐ MALE	

PREFFERED METHOD OF APPOINTMENT? ☐ PHONE CALL ☐ TEXT MESSAGE ☐ EMAIL

HOW DID YOU HEAR ABOUT OUR OFFICE?

EMAIL ADDRESS

EMPLOYER NAME AND ADDRESS

REFERRRING DOCTOR AND ADDRESS

EMERGENCY CONTACTS

CONTACT NAME	RELATIONSHIP	PHONE NUMBER

202 Union Avenue, Ste. K, Brooklyn, NY 11211 • Phone: (718) 387-7420 • Fax: (718) 387-7421
www.bbwphysicaltherapy.com

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MEDICAL HISTORY

1. Reason for physical therapy visit: _____
   Please describe your current symptoms:
   _____
   _____

2. **Is your condition work related or due to a motor vehicle accident?** ☐ YES ☐ NO
   IF YES, PLEASE INFORM THE FRONT OFFICE.

3. Have you had surgery for this condition? If so, please describe the procedure including the date of surgery:
   _____
   _____

4. Are you taking any medication for this condition? If so please list below:
   _____

5. Have you had physical therapy or any other treatment for this condition in the past?
   If so, please describe your previous treatment:
   _____
   _____

6. When did your symptoms or injury first occur? Did your symptoms arise gradually or suddenly? Please describe:
   _____
   _____

7. Rate your current level of pain on a scale of 0 – 10 (0 = no pain, 10 = excruciating pain) _____
8. Is your pain constant or intermittent? _____
9. Does your pain wake you up at night? ☐ YES ☐ NO
10. What activities make your pain worse?
    _____
11. Does your pain follow a pattern where it is worse in the AM or PM? _____
12. Do you have radiating pain that could be described as burning or electrical? ☐ YES ☐ NO
13. Do you have numbness or tingling in your one or more extremities (leg or arm)? ☐ YES ☐ NO
14. Please describe your current functional limitations (walking, stairs, getting out of bed, recreational activities, ect.) _____
    _____
15. Please list your normal recreational or sport related activities when healthy:
    _____
    _____

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Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for Brooklyn Body Works Physical Therapy, PC to furnish the medical care and treatment considered necessary in assessing or treating my physical and mental condition.

Patient/ Responsible Party_____ Date: _____

Benefit Assignment/Release of Information

I hereby assign all medical benefits to which I am entitled, including that from Medicare, Medicaid, private insurance and third-party payers to Brooklyn Body Works Physical Therapy, PC. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize BBW to release all information necessary, including Medical Records, to secure payment.

Patient/ Responsible Party_____ Date: _____

Financial Policy Statement

Brooklyn Body Works Physical Therapy will bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill for services rendered. We require that arrangements for payment of your estimated share be made today. We accept cash, personal checks, money orders/ cashier's checks, and Person-to-Person online bank payments (ex: Chase Quick-Pay).

If your insurance carrier does not remit payment within 90 days, we reserve the right to collect balance in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your insurance company establishes an internal *usual and customary fee schedule*, you will be responsible for the difference remaining.

If your insurance company makes any payments directly to you for services rendered by us, you recognize an obligation to promptly remit same to Brooklyn Body Works Physical Therapy, PC.

For all Medicare beneficiaries, as of January 1, 2017, you are entitled to a total of $1980 of combined physical therapy and speech benefits. For more specific information regarding your Medicare physical therapy benefits and financial responsibility, please refer to our BBWPT Medicare benefit information handout or speak directly to a BBWPT representative.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed to Brooklyn Body Works Physical Therapy, including court costs, collection agency fees and attorney fees.

COPAY PER VISIT:_____

NOTE: ESTIMATED COVERAGE INFORMATION IS PROVIDED AS A COURTESY TO OUR PATIENTS BUT IS NOT INTENDED TO RELEASE THEM FROM TOTAL RESPONSIBILITY FOR THEIR ACCOUNT BALANCE. THE ABOVE INFORMATION HAS BEEN READ AND EXPLAINED TO ME.
I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT

Patient/Guardian Signature_____ Date: _____

BBW PT Representative_____ Date: _____

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PATIENT AGREEMENT

- New York State law requires that patients obtain a written prescription before initiating treatment by a licensed physical therapist if they are to use their insurance benefits to pay for treatment.
- Patient is responsible to inform BBWPT, PC of any changes in insurance coverage prior to that change. If the patient fails to inform BBWPT, PC of a change in insurance coverage, the patient will be held responsible for any unpaid claims related to a lapse or change in benefits. This includes MEDICARE patients who are under Home Health Care or those who choose a Medicare Advantage plan.
- The patient is responsible for all co-payments and deductibles prior to receiving treatment.
- All visits are by appointment only and generally last about an hour.
- IT IS THE PATIENT'S RESPONSIBILITY TO CONFIRM ALL APPOINTMENTS. Our office sends courtesy text or email reminders. If a patient does not confirm their appointment, our office reserves the right to void their appointment and offer it to a wait listed patient.
- We request that patients call if they are going to be late. If a patient is more than 15 minutes late for an appointment, Brooklyn Body Works PT, PC reserves the right to cancel the appointment. Remember, this is your scheduled time and the therapist's time is just as valuable as your own time.
- WE REQUEST 24 HOURS NOTIFICATION IN THE EVENT OF A CANCELLED APPOINTMENT. If appropriate notice in not given a charge of $50 will be assessed to the patient. We understand that sometimes last-minute cancelations are unavoidable. Individual circumstances may be discussed with the office manager.
- **Should a patient cancel or no-show repeatedly within the course of treatment, the patient may be taken off the schedule and may forfeit all future appointments. Workman's compensation and no-fault patients also risk losing their benefits for physical therapy services and/or may face other legal consequences for non-compliance with care.**

☐ I understand that I am responsible for my deductible and copayments.

☐ I hereby state that I am not eligible for NYS No-Fault or NYS Workman's Compensation Insurance.

☐ I agree to inform BBWPT, PC of any changes in my insurance coverage or benefits prior to the effective date of these changes.

☐ I understand that I am responsible for my appointments and if I fail to give appropriate notice I am responsible for any late cancelation or no-show fees.

I AGREE TO TREATMENT ON THE ABOVE TERMS.

Name_____ Date_____

Signature_____

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PATIENT HIPAA AWARENESS AGREEMENT

With my permission, BROOKLYN BODYWORKS PHYSICAL THERAPY PC, (THE PRACTICE) may use and disclose protected health information about me to carry out treatment, payment and healthcare operations (TPO). Please refer to BROOKLYN BODYWORKS PHYSICAL THERAPY'S Notice of Privacy Practices for a more complete description of such uses and disclosures.

A copy of the Notice of Privacy Practices was made available to me prior to signing this consent. The Practice reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of BROOKLYN BODYWORKS PHYSICAL THERAPY PC may call my home or other designated locations and leave a message on voicemail, or in person, in reference to any items that may assist The Practice in carrying out TPO, such as appointment reminders, insurance matters and any information pertaining to billing/collections or my clinical care.

With my permission, the office of BROOKLYN BODYWORKS PHYSICAL THERAPY PC may mail to my home or other designated location any items that assist The Practice in carrying out TPO such as appointment reminder cards and patient statements as long as they are marked PERSONAL AND CONFIDENTIAL. I have the right to request that The Practice restrict how it uses or discloses my Personal Health Information to carry out TPO. However, The Practice is not required to agree with my requested restrictions, though if it does so, it is bound by this agreement.

By signing this agreement, I am allowing BROOKLYN BODYWORKS PHYSICAL THERAPY PC to use and disclose my PHI for TPO.

I may revoke my consent in writing except to the extent that The Practice has already made disclosures in reliance upon my prior consent.

PATIENT'S SIGNATURE _____ DATE _____

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PATIENT'S COPY

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