THE BIOMECHANICS – Physical Therapy and Sports Medicine

Patient Information:

Last Name _____First _____Middle_____

Date of Birth ____/____/____/ Sex: M F

Employer's Name _____

School_____

Contact Information:

Mailing Address _____ City _____State _____ Zip Code_____

Home Phone ( ) _____-_____ Cell Phone ( ) _____-_____ Other ( ) _____-_____

Which is your primary contact preference (please circle) Home Cell Other

Emergency Contact Name _____ Relationship _____Phone_____

May we leave a message with medical information on your primary contact preference? Yes No

Who do you authorize our office to share medical information with? _____

Email Address _____ May we contact you for reminders via Email? Yes No

Physician Information:

Primary Care Physician _____Phone #_____

Referring Physician _____Phone # _____

Insurance Information:

Primary Insurance _____ Policy ID # _____ Group _____

Policy Holder's Name (if other than yourself): _____ Date of Birth ____/____/____

Relationship to Policy Holder? _____

Secondary Insurance _____ Policy ID # _____ Group _____

Policy Holder's Name (if other than yourself): _____ Date of Birth ____/____/____

Relationship to Policy Holder? _____

- I do hereby consent to such treatment by the authorized personnel of The BioMechanics LLC as may be dictated by prudent medical practice by my illness, injury or condition. This consent is intended as a waiver of liability for such treatment except acts of negligence.
- I, the undersigned, hereby authorize assignments of benefits from Medicare or other insurance companies to The BioMechanics LLC for services furnished to me. I further agree and acknowledge that my signature on this document authorizes The BioMechanics LLC to obtain and release any medical information to Medicare or other insurance companies necessary to process my claim(s), including determining eligibility and seeking reimbursement for services provided.
- I understand and accept the terms of The BioMechanics LLC Clinic Policies. I understand that I am financially responsible for all charges whether or not paid by insurance.
- I have received a copy of the Notice of Patient Information Practices and hereby consent to the use and disclosure of my health information for purposes as noted in the Notice. I understand I retain the right to revoke or restrict this consent by notifying the Company in writing at any time.

Patient/ Responsible Party Printed Name _____

Patient or Responsible Party Signature _____ Date ____ /____ /____

CLINIC POLICIES

WELCOME TO THE BIOMECHANICS – Physical Therapy and Sports Medicine!

Attire: Loose fitting comfortable attire is recommended during treatment sessions.

Appointments: It is important that you receive consistency of treatment and that you attend all appointments as scheduled. We will try to accommodate your schedule to our best ability and therefore ask you to schedule your full prescription frequency after your initial appointment. We ask that you please be on time for your appointments. If you are late for your appointment, it will be up to the discretion of your therapist whether or not you will be seen. This is a courtesy to the other patients that are scheduled.

Cancellation/ No-show: If you need to cancel, we ask that you please call 24 hours prior to your scheduled time. If you fail to give notice this will count as a "no-show", and after two consecutive no-shows all further appointments will be deleted and the referring physician may be informed. We reserve the right to collect a *$25 no-show fee* (this includes appointments not cancelled 24 hours in advance).

Compliance: We are obligated to inform your insurance company and physician if you are noncompliant. If you are a workman's compensation patient we are also obligated to inform your case worker.

Benefits and Payments: **We will try to verify benefits from your insurance company. However this is a quote and estimate from your insurance company and NOT a guarantee of benefits. Please be advised that any changes of your benefits are your responsibility, and we ask you inform us if you receive information regarding changes. We will bill your insurance companies as a courtesy. However, all co-pays, deductibles and co-insurances are due at time of service. Any remaining balance will be sent by statement. Any overpayments will be refunded after all charges have been processed by your insurance companies.**

If you have a worker's compensation claim, please note that you will remain financially responsible for any and all charges if your carrier denies coverage or if your claim is contested.

Self-pay balances are due at the time of service. Please be advised that we are not a credit grantor, and therefore, failure to maintain any arrangements may result in the placement of your account with an agency or attorney for collection.

Please be aware that you will remain financially responsible for any and all services and supplies received regardless of payment options discussed above. In the event your account becomes delinquent and is therefore in default of payment, the patient, legal guardian, or admitting parent will be responsible for the principle amount owed and all reasonable costs associated with the collection of this debt, including but not limited to: collection service fees, attorney's fees, all court costs, and additional legal expenses associated with recovery of the debt.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

The BioMechanics LLC Legal Duty:
The Company is required by law to protect the privacy of your personal health information, provide this notice about our practices and follow the information practices that are described herein.

Uses and Disclosures of Health Information:
The BioMechanics LLC uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and in evaluating the quality of care we provide. For example, we may use your personal health information to contact you to provide appointment reminders or information about treatment alternatives or other health related benefits that could be of interest to you. Certain aspects of our services are performed through contracts with outside persons or organizations. We require these business associates to appropriately safeguard the privacy of your information.

The BioMechanics LLC may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, and for emergencies. We may provide de-identified information for research studies. We may also provide information as required by law.

In any other situations, we are to obtain your written authorization before disclosing your personal health information. If you chose to provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

The BioMechanics LLC may change its policy at any time. When changes are made a new Notice of Privacy Practices will be posted in a common area of our clinic. You may also request an updated copy of the practices at any time. The Notice is also available on our website at www.thebiomechanics.net.

Patients' Rights:
You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative operations except when specifically authorized by you, when required by law or in emergency situations. These requests will be considered on a case-by-case basis, but the Company is not legally required to accept them. If you have paid for a health care item or service in full, out of pocket, we must honor your request to restrict information from being disclosed to a health plan for purposes of payment or operations. You have the right to request that we not send you any future marketing or fundraising materials, and we will use our best efforts to honor such requests.

Concerns and Complaints:
If you are concerned that The BioMechanics LLC may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact clinic director or company owners. You may also send a written complaint to the US Department of Health and Human Services in Washington D.C in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION

If you have questions, or need further assistance, you may contact the Privacy Officer or business owners at:
The BioMechanics LLC
1983 Commerce Center Circle
Prescott, AZ 86301
928-771-1700

As a patient, you retain the right to obtain a paper copy of this Notice of Privacy Practices, even if you have requested such copy by e-mail or other electronic means.

EFFECTIVE DATE
This Notice of Privacy Practices is effective August 1, 2015.

PATIENT/CLIENT MEDICAL HISTORY
Please fill out this form as completely as you can as much of this information is Required by Insurances

Name: _____ Date:_____

DOB: ____/_____/_____ Age:_____ Height:_____ Weight: _____

Name of Doctor: _____

Reason for visit:_____

Who referred you to The BioMechanics? _____

Date of Onset/Injury: _____/_____/_____ unknown Date of Surgery:____/_____/_____

Occupation _____ Retired Since: _____ /_____/_____

Work Related: Yes No (circle) Auto Related: Yes No (circle)

Previous Surgeries/Dates:
_____

Previous Physical Therapy/Dates:
_____

Previous X-Rays/CT Scans/MRI's/Dates:
_____

Known Medical Allergies:
_____

Please List Current Medications and Supplements or Attach Print Out

Drug Name	Prescribed, Over The Counter, Supplement	Dosage	Frequency

PATIENT/CLIENT MEDICAL HISTORY

Name: _____ Date:_____

DOB: ____/_____/_____

Difficulties/Problems with any of the following: (please Check all that apply and Describe below)

Head		Heart		High Blood Pressure		Cancer	
Eyes		Lungs		Heart Attacks		Angina/Chest Pain	
Ears		Ulcers		Gall Bladder		Urinary Tract Infection	
Nose		Asthma		Passing Blood		Polio	
Throat		Bowels		Diabetes/hypoglycemia		Headaches	
Kidneys		Arthritis		Stroke		Allergies	

******If** you answered **yes** to any above, or have another medical condition not listed,
please describe below:

_____

_____

_____

_____

Have you had any unexplained weight loss in the last month? YES NO

Do you exercise regularly? YES NO

Do you have difficulty sleeping? YES NO

Do you experience episodes of dizziness? YES NO

How many falls have you had in the last 12 months? (circle) 0 1 2 more than 2

Were you injured in any of the falls? YES NO

PATIENT/CLIENT MEDICAL HISTORY

Name: _____ Date:_____

DOB: ____/_____/_____

Describe the character of your current pain (you may choose more than one):

___Sharp	___Numbness	___Dull	___Shooting
___Stabbing	___Soreness	___Aches	___Throbbing
___Burning	___Weakness	___Tingling	

How often are the complaints present?
___Constant (76-100%) ____Frequent (51-75%) ___Occasional (26-50%) ___Intermittent (1% -25%)

What aggravates the pain? _____

What alleviates the pain?_____

Visual Pain Rating Scale

Please rate your pain by circling the most appropriate number below.

1. At Worst (NO pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)
2. Current (NO pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)
3. At Best (NO pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

On the following diagrams, indicate all areas of:

Pain xxxxxx

Stiffness //////////

Numbness oooooo

Other (specify) _____