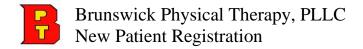
## HIPAA Consent to Use and Disclosure of Protected Health Information

Date:	
Name:	DOB:/
and its representatives to furnish medical infrecords to my referring physician(s) and to records to my referring physician(s) and to reduce the responsibility of the responsibility. I also that this office bills insurance as a courter that the representatives to furnish medical infreedring the records and to records a service is ultimately my responsibility. I also that this office bills insurance as a courter that the representatives to furnish medical infreedring the records and to records a service is ultimately my responsibility. I also that this office bills insurance as a courter that the responsibility is a service in the records and the records are records as a service is ultimately my responsibility.	y authorize Brunswick Physical Therapy, PLLC. formation, including e-mail of faxed copies of my my insurance company, if requested. As a patient that payment for today's service and any future authorize a representative of Brunswick Physical e carrier on my behalf if required. I understand esy and that payment of the charges for these ohic copy of this authorization shall be as valid as
PLLC. for purposes of appointment remind Privacy Practices before signing this consen Brunswick Physical Therapy, PLLC. to dis	nd postcards from Brunswick Physical Therapy, lers. I am aware that I can review the Notice of it (available at the front desk). I hereby authorize sclose the information about myself (or another that is protected under federal law for treatment,
individual(s) about my condition or treatme	apy, PLLC. to communicate with the following nt. In accordance with federal laws, I understand om individuals (including family members) unless
Name	Relationship to Patient
X	

Effective Date: This notice is in effect on or after December 23, 2019

Signature of Patient, Parent, or Legal Guardian



## **Payment Policy**

All co-pays are due at time of treatment.

Payment may be made by check or cash. (Checks can be made out to BPT). We also accept credit/debit card payments as wellas Flex Spending Account (FSA) or Health Savings Account (HSA) cards.

A \$20 service fee will be charged for checks returned for any reason.

Any bills submitted to the patient are payable upon receipt.

#### **Attendance**

Your regular attendance is critical to your success. If you find it necessary to cancel an appointment for any reason, we require 24 hours' notice. You may be charged a \$30 fee for a late cancellation.

No shows will be charged a \$30 fee which is not covered under your insurance benefit.

(2) No shows will consist in an immediate discharge from physical therapy.

I understand and agree to the office procedures outlined above.

X	X
Patient Signature/Responsible Party	Date

## **Assignment and Release**

I, the undersigned, certify that I (or my depen	ident) hav	ve insurance coverage with
an (Patients Primary Insurance Carrier)	d assign	directly to Brunswick Physical
Therapy, PLLC. all insurance benefits if any	y, otherw	ise payable to me for services rendered
I understand that I am financially responsible	for ask cl	narges whether or not paid by insurance
I hereby authorize the Physical Therapist/Bru	ınswick I	Physical Therapy, PLLC. the use of this
signature on all insurance		
submissions.		
X		
Patients Printed Name		
X		
Signature of Patient/Responsible Party		Date



# "Movement for Life"

## Brunswick Physical Therapy, PLLC. Medical History

Date:

**Patient Name:** 

		Prescripti	on Medication	ons			
Name of Med	dication	Dosage Ex (mg, cc)		Freque Ex (2 x		More Info if	needed
Surgery D (Past & Pre		Body Part		Aller	gies	Reactio	on
	Place an '	"X" for all that apply to v	what you are	being seen	for today only:		
X-Ray		Ct Scan			MRI		
Ultrasound		Bone Scan			Blood Test		
EMG		NCV			Other:		
	Ple	ease list any other inform	mation you f	eel we shou	ld know		
F	Place an "X" if y	ou have experienced or	been told th	at you have	any of the follow	wing:	
Asthma		Kidney Disease	Kidney Disease		Fainting		
Emphysema			Hepatitis/Jaundice		Migraine/Headaches		
Chest Pain		Bowel/Bladder Problems			Osteoporosis		
Heart Disease		Blood Disorder			Cancer		
Stroke		Pregnancy			Visual Loss		
Dizziness		Shortness of Breath			Hearing Loss		
Epilepsy/Seizures		High Blood Pressure		Chemical Dependency			
Arthritis		Blood Clot			Depression		
Diabetes		Head Injury/Concussion			Anxiety		
Fibromyalgia		Any Neurological I	Any Neurological Diseases		Thyroid Problems		
AIDS/HIV		Other:					



### Brunswick Physical Therapy, PLLC. Medical History (PART II)

Patient Name:	Date:
AD Follow Update:	
Briefly describe your symptoms :	
When did your symptoms start?	
How did your symptoms start?	
What makes your symptoms better? (circle all that apply): Sitting  Lying Down Walking Other:	
• What makes your symptoms worse? (circle all that apply): Sitting	Standing Bending
Reaching Lifting Bending Lying Down Walking Other:	
• Is your pain Constant / Intermittent / Not applicable	
ow would you rate your pain?	
At Best 0 1 2 3 4 5 6 7 8 9 10 No Pain Worst Pain	
At worst 0 1 2 3 4 5 6 7 8 9 10 No Pain Worst Pain	
Today 0 1 2 3 4 5 6 7 8 9 10 No Pain Worst Pain	