

9881 Broken Land Parkway
Woodmere I, Suite 103
Columbia, MD 21046
TEL 240.841.2639
FAX 240.841.2644
www.BWtherapy.com

Patient Information

Last Name: First Name: MI

Gender: M F Date of Birth: Marital Status: Single Married Divorced

Address: Street City State Zip

Home Phone: Cell Phone: Work Phone:

SSN: - -

Emergency Contact Name: Relation:

Home Phone: Work Phone: Cell Phone:

Employment Information Full- Time Part-Time Self-Employed Not Employed

Occupation / Title:

Name of Employer:

Address: Street City State Zip

Physician Information

Primary Care Doctor: Phone:

Referring Doctor: Phone:

Primary Insurance

Insurance: ID Group #

Effective Date (Medicare)

Name of Cardholder: Relationship to Patient:

Date of birth of cardholder: Co-payment:

Secondary Insurance

Insurance: ID Group #

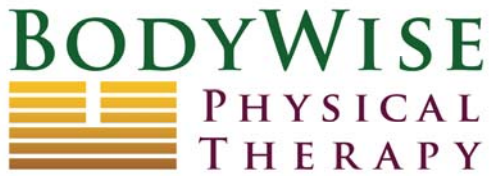
Effective Date (Medicare)

Name of Cardholder: Relationship to Patient:

Date of birth of cardholder: Co-payment

Patient Signature

Date:



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MEDICAL HISTORY

Name: _____

The reason(s) you are here: _____

Date of Injury: _____ Is this a work injury? _____ Is this a result of a motor vehicle accident? _____

Is the injury/accident the fault of another party? _____

Since the onset of this injury /condition, have you received any of the following? (please circle all that apply):

- X-Ray MRI CT Scan Injections Massage Therapy Chiropractic Bone Scan
Nerve Blocks Physical Therapy Acupuncture Other _____

Do you have a history of any of the following? (please circle all that apply):

- Heart disease Cancer Diabetes Shortness of Breath Allergies Metal Implants
Pace maker Hypoglycemia High Blood Pressure Stroke Osteoporosis Chest Pain
Other _____

If you have ever been hospitalized for a serious medical illness or operation, please list the most recent ones below (do not include normal pregnancies).

Table with 2 columns: Year, Operation / Illness. Includes 4 rows of blank lines for data entry.

Medicines:

What prescription drugs are you taking? For what condition?

What over-the-counter medications, herbs, or supplements are you currently taking? For what condition?

Personal Lifestyle Habits: For each item, please indicate how much, how many, or how often. Please note if this is current or the date that you quit.

Cigarettes (packs) _____
 Coffee / Tea (cups) _____
 Alcohol (drinks per week) _____
 Illicit Drugs: _____

For the following, please put a **“C”** if the condition is current or a **“P”** if you had it in the past.

General

- Insomnia
- Dreams / nightmares
- Fatigue
- Poor memory
- Strong desire for cold drinks
- Strong desire for hot drinks
- Significant weight loss/gain
- Cold hands & feet
- Chills
- Fever

Head & Neck

- Headaches
- Migraines
- Stiff Neck
- Dizziness
- Fainting
- Swollen glands

Ears

- Ringing
- Hearing loss
- Hearing aides
- Infections
- Earache
- Vertigo

Eyes

- Glasses/ contact lenses
- Blurred vision
- Poor night vision
- Spots or floaters
- Eye inflammation
- Dry eyes
- Double vision
- Glaucoma
- Cataracts

Nose, Throat, & Mouth

- Sinus infection
- Hay fever / allergies
- Frequent sore throat
- Difficulty swallowing
- Mouth & tongue ulcers
- Frequent colds
- Nosebleeds
- Dry nose

- Nasal congestion
- Loss of voice
- Thirst
- Excessive phlegm
- TMJ pain/dysfunction
- Facial pain
- Gum problems
- Dry mouth

Skin

- Hives
- Rashes
- Eczema
- Psoriasis
- Excess sweating
- Night sweating
- Dry skin
- Easily bruised
- Changes in moles, lumps
- Itching

Respiratory

- Difficulty breathing
- Difficulty breathing, reclined
- Wheezing
- Asthma
- Chronic cough
- Wet cough
- Coughing up phlegm
- Coughing up blood
- Shortness of breath
- Tight chest
- Pneumonia

Cardiovascular

- High blood pressure
- Low blood pressure
- Chest pain or tightness
- Palpitation
- Rapid heart beat
- Irregular heart beat
- Swollen ankles
- Phlebitis
- Anemia
- Heart attack
- Stroke

Gastrointestinal

- Nausea
- Indigestion
- Stomach pain
- Diarrhea
- Constipation
- Poor appetite
- Excessive hunger
- Vomiting
- Gas
- Hiccups
- Acid reflux
- Bloating
- Bad breath
- Laxative use
- Bloody stool
- Hemorrhoids

Musculoskeletal

- Joint pain/ arthritis
- Sore muscles
- Weak muscles
- Difficulty walking
- Neck/shoulder pain
- Upper back pain
- Lower back pain
- Rib pain
- Other _____

Urinary

- Pain with urination
- Frequent urination
- Urgency
- Blood in urine
- Incontinence/ leaking
- Incomplete urination
- Bedwetting
- Wake to urinate
- Kidney stones
- Bladder / urinary infections

Neurological

- Seizures
- Tremors
- Numbness or tingling
- Paralysis
- Poor coordination
- Loss of balance
- Other _____

Mental / Emotional

- Depression
- Mood swings
- Irritability
- Difficulty relaxing
- Loneliness
- Sensitive
- Shy
- Cry often
- Worry often
- Compulsive behaviors
- Difficulty concentrating
- Hopeless outlook
- Suicidal thoughts
- Lose temper
- Frustration

Male Genital / Sexual

- Impotence
- Premature ejaculation
- Nocturnal emission
- Pain / itching of genitalia
- Lumps in testicles
- Increased libido
- Low libido

Gynecology / Female Sexual

- Pregnant
- # of pregnancies
- Miscarriage
- Abortion
- Menopause
- Hormone Replacement
- Irregular Periods
- Menstrual Cramps
- Breast tenderness
- Breast lumps, cysts
- Abnormal pap smear
- Vaginal infections
- Vaginal pain/ itching
- Excessive vaginal discharge
- Yeast infections
- Uterine fibroids
- Ovarian cysts
- Endometriosis
- PMS
- Increased libido
- Low libido

Signature _____

Date _____



Assignment of Medical Benefits, Payment Responsibility & Authorization for Physical Therapy Treatment

Patient: _____

1. THE UNDERSIGNED Patient or Patient's Legal Representative hereby authorizes BodyWise Physical Therapy & Acupuncture, LLC ("Provider") to render to Patient physical therapy and occupational therapy services which the Provider or Patient's treating physician determines may be necessary or advisable. Patient agrees to cooperate with all reasonable requests by Provider in connection with Provider's rendition of therapy services (collectively, the "Therapy Services").
2. THE UNDERSIGNED Patient or Patient's Legal Representative hereby certifies that all information provided to Provider by the undersigned including any information in connection with applying for payment under title XVII of the Social Security Act, is true and accurate in all respects.
3. THE UNDERSIGNED Patient or Patient's Legal Representative hereby authorizes Provider to disclose any information, furnished to Provider or obtained by Provider in connection with patient's treatment (including information concerning a related Medicare claim), to any physician, governmental agency (including the Social Security Administration or any of its intermediaries or carriers), insurance company or health care facility requesting such information.
4. THE UNDERSIGNED Patient or Patient's Legal Representative hereby assigns to Provider all Medicare benefits and Medicaid benefits, and any other insurance benefits, whether private or public), to which patient may be entitled for any Therapy Services rendered by Provider as well as the right to collect such insurance benefits on behalf of the patient. The undersigned hereby authorizes and directs Provider to apply and file for all such insurance benefits on behalf of patient.
5. THE UNDERSIGNED Patient or Patient's Legal Representative hereby assigns to Provider all private medical insurance benefits (primary and secondary, including Medigap providers) or other benefits to which Patient may be entitled for any Therapy Services rendered by Provider as well as the right to collect such insurance benefits. The undersigned hereby authorizes and directs Provider to apply and file for all such insurance benefits on behalf of Patient.
6. THE UNDERSIGNED Patient or Patient's Legal Representative hereby agrees that the patient shall be financially responsible for any portion of Provider's charge that are not paid by the patient's insurance carrier but are rightfully owed by patient pursuant to patient's agreement with such insurance carrier. In the event the patient does not have insurance coverage such patient shall be responsible for all Provider charges and expenses..
7. THE UNDERSIGNED Patient or Patient's Legal Representative agrees to execute any documents and perform any acts the Provider may reasonably request. The undersigned warrants and represents that attached hereto are originals or certified copies of any applicable powers of attorney, health care surrogate forms or court orders appointing the undersigned as the legal guardian of patient. The undersigned, if not the patient but the patient's legal representative, represents and warrants that he or she presently has the full right and authority to execute this agreement on behalf of the patient (and thus bind the patient) to the terms and conditions set forth herein.
8. THE UNDERSIGNED Patient or Patient's Legal Representative hereby agrees that the provisions hereof shall continue in full force and effect until Provider has received written notice of termination signed by the undersigned provided; however, that the provisions of paragraphs 2, 4, 5, and 6 shall survive such termination.



Effective Date: April 1, 2009

NOTICE OF PRIVACY & DISCLOSURE 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 law requires that we maintain the privacy of your medical information. We are required to follow the terms of this notice and to notify you if we are unable to grant your request to disclose or restrict disclosure of your health information to others. We reserve the right to make changes to our practices and this notice, and we promise to make a good faith effort to notify you of any changes.

Your health information will be routinely used for treatment, consultation, payment and quality monitoring, and your consent or the opportunity to object or agree is not required in these instances. Your medical information may be shared with others involved in your care or providing consultation about your treatment. We may use and disclose your medical information to your insurance plan or third-party payer with accompanying documentation that identifies you, your diagnosis and/or practitioner's impressions and procedures performed. Your information may be reviewed for risk management or quality improvement purposes.

We may, as part of routine practice, use and disclose some or all of your health information to family members, a close personal friend identified by you, or other personal representative in order to help with your health care or assist with the payment of your health care. You have the right to request restrictions on these uses. For any other use or disclosure, we will first obtain your written authorization before disclosing your personal health information. You can revoke an authorization at any time by notifying our office in writing.

Additional disclosures are required by law and do not require your consent. These include: the disclosure of health information to the FDA related to any adverse effects of food, supplements, products, and product defects for surveillance to enable product recalls, repairs, or replacements; the release of health information to worker's compensation to the extent authorized by law; the disclosure of health information to public health and or legal authorities to avert a serious threat to public health or safety, to report communicable disease, injury, or disability or to comply with mandated reporting requirements for tracking of birth and morbidity; and the disclosure of your health information as required under state and federal law to the appropriate law enforcement officials, public health authorities, and/or attorneys: (1) in response to a valid subpoena, (2) in the event of suspected unlawful conduct of a practitioner or violations of professional standards; (3) when a patient is the suspected victim of abuse, neglect or domestic violence.

Your health record is the property of BodyWise Physical Therapy & Acupuncture, LLC, but the content is about you, and therefore belongs to you. You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information list in this notice. If we are unable to accommodate your request, we will charge you a reasonable cost-based fee for expenses such as copies, postage, staff time and other expenses as applicable. You have the right to receive a list of instances in which we or our business associate disclosed your health information for purposes other than treatment, payment, health care operation and certain other activities for the last six (6) years, but not before the effective date of this notice. If you request this accounting more than one in a twelve (12) month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. You have the right to request restrictions on the uses and disclosures of your health record. Your request must be made in writing and must specify your additional restriction. You have the right to receive confidential communications and to request such communication by alternate means or to alternate locations should we need to contact you. Your request must be made in writing and must specify the alternative means necessary. You will be notified if we are unable to accommodate your request. You have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. You will be notified if we are unable to accommodate any of the above requests.

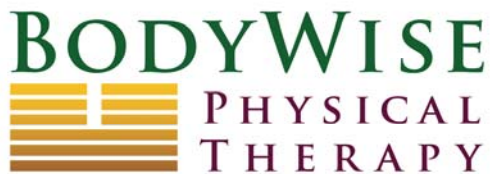
To receive additional information or report a problem, you may contact our clinic administrator at 240-841-2639. If you believe your privacy rights have been violated, you have the right to file a complaint with us by contacting our clinic administrator and/or with the U.S. Secretary of Health and Human Services with no fear of retaliation by this office. Office for Civil Rights Hotline: 1-800-368-1019

I hereby acknowledge my receipt and understanding of the **Notice of Privacy & Disclosure Practices** and agree to the policies and practices set forth herein.

Signature of Patient or Personal Representative

Date

Printed Name of Patient or Personal Representative



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CANCELLATION & MISSED APPOINTMENT POLICY

- Please be advised that we require 24 hrs. *notice* for appointment cancellations.
- Our fee for a late cancellation or failure to show for an appointment is \$50.00.
- We reserve the right to discharge you from Physical Therapy services if you miss more than three consecutive scheduled appointments.

LATENESS POLICY

Please be advised that if you are more than 10 minutes late for your scheduled appointment, we may not be able to accommodate you for your session or may only be able to provide partial treatment.

We thank you for your cooperation and integrity.

I have read and understand the above stated policies, and I will honor them accordingly.

Signature

Date

Printed Name