BodyGears
Physical Therapy
Enhancing Human Mechanics

www.BodyGears.com 877-709-1090

* WORKERS' COMPENSATION INFORMATION

Work-related Injury? ☐ Yes ☐ No		Date of Accident: (mm/dd/yyyy)	
Name of Workers' Compensation Carrier:		Claim Number:	
What part of the body was injured?			
Address:	City:	State:	Zip:
Phone Number:		Last Date Worked?	
Employer's Name:		Employer's Contact Number:	
Adjuster's Name:		Adjuster's Phone Number:	

* ACCIDENT INFORMATION

Motor Vehicle/Personal Related Injury? ☐ Yes ☐ No		Accident Date:	
Motor Vehicle Compensation Carrier:		Claim Number:	
Address:	City:	State:	Zip:
Phone Number:	Last Work Date:	State Accident Occurred:	

* ATTORNEY INFORMATION

Attorney's Name (if lawsuit is involved):		Phone Number:	
Address:	City:	State:	Zip:

I, the undersigned, hereby certify that have answer the questions listed above accurately and to the best of my knowledge.

Patient/ Parent or Guardian Signature:	Date:

Fields marked with an (*) are optional.


PRINT

FILL OUT

FAX to **866-221-3400**
& bring to your appointment.

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FINANCIAL POLICY

ALL PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE **Initials** _____ *(for the information below)*

Please note, all Patient Responsibility Payments are due at time of service unless other arrangement were made prior to initial appointment. This includes all deductible, co-insurance, and co-payment amounts.

Also, please note that payments made at time of service are for an **estimated** amount based on benefit information provided by your insurance company, and **not the exact** amount you will owe for any given date of service. Final dollar amount due for services will be **determined after** your insurance processes your claim.

The clinic accepts cash, personal checks (in-state only), VISA, MasterCard, American Express, and Discover. There is a $25.00 service charge for returned checks. All patients are required to supply the clinic with a valid credit or debit card prior to their first visit to ensure timely payment of insurance non-payment and owed amounts.

Patients with outstanding balances 60 days or older authorize the clinic to charge their credit or debit card on file for the balance due. If we are unable to collect payment from your debit or credit card on file we may forward your account to a third party collection agency. Please note we will not book any additional appointments until your balance has been paid in full.

For patients covered, or who will be covered, by a COBRA plan, we must able to confirm coverage within 30 days of the last date of service. After 30 days, if we are unable to verify active coverage, you will be responsible for payment of any services rendered.

INSURANCE **Initials** _____ *(for the information below)*

Our office will check your benefits as a courtesy to you and provide this information on or before your first appointment. The benefit information we will provide for you is only a quote of benefits, so it is not a guarantee that we will receive payment from your insurance company for services rendered. The actual benefit for services provided will be determined by your insurance once they receive your claim.

We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible, co-insurance, and/or co-payment at the time of service. If we have not received payment from your insurance company within 60 days of the date of service, you may be expected to pay the balance in full. Please note, even though we will bill your insurance carrier, you are still responsible for payment of all services rendered whether by you or your insurance company.

We do not bill secondary insurance companies. However, we will provide all necessary receipts for you to be able to submit your claim to your secondary insurance carrier. For patients covered by Medicare, please ensure you have set up claims crossover with Medicare to your secondary, or supplemental plan.

REFUNDS **Initials** _____ *(for the information below)*

Patient/guarantor credits in amounts less than $20.00 will be retained on account to be credited toward future balances unless a written request for refund is received. Amounts $20.00 and greater will automatically be refunded to the patient/guarantor once all charges are covered.

I have read and understand the Clinic's Financial Policy. I agree to assign insurance benefits to the Clinic's Practice whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I may also be responsible for the fee charged by the collection agency for cost of collections.

Signature _____ Date _____


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PATIENT MEDICAL HISTORY

Name: _____

Diagnosis/What body part(s) you are being referred for:

_____

Dates Symptoms Began: _____

Please Check: ☐ Work Injury ☐ Motor Vehicle Accident
☐ Other _____

Did this injury require surgery? ☐ Yes ☐ No

Kind of surgery and Date: _____

What medications are you taking for your current injury (if any)?

_____

_____

Please list all Medications:

_____

_____

Mark on the scale below your pre-injury level of function:
☐ 0% ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50%
☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

Mark on the scale below your present level of function:
☐ 0% ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50%
☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

Please describe the location of your pain:

_____

Please indicate which of these words, if any, describe your pain. Check all that apply.
☐ Aching ☐ Numb ☐ Shooting ☐ Tingling
☐ Burning ☐ Sharp ☐ Throbbing

Rate your pain intensity on a scale of 0-10. (0 being no pain)
Current pain _____ /10
At best _____ /10
At worst _____ /10

Which activities increase your symptoms? Check all that apply.
☐ Bending ☐ Reaching ☐ Squatting ☐ Walking
☐ Driving ☐ Reclining ☐ Stairs
☐ Kneeling ☐ Rising ☐ Standing
☐ Lifting ☐ Sitting ☐ Twisting
☐ Other _____

What eases your symptoms?
☐ Moist Heat ☐ Ice Application ☐ Medication
☐ Rest ☐ Change in position
☐ Other _____

Normal Physical Work Activities:

_____

_____

Is your condition overall:
☐ Improving ☐ Getting Worse ☐ Staying the same

Have you had any treatment of this current problem in the past?
☐ Yes ☐ No

Have you received any of the following tests for this problem?
☐ X-rays ☐ CT Scan ☐ Bone Scan
☐ EMG ☐ Nerve Conduction Study ☐ MRI
☐ Other _____

Medical History Information: If you have/had any of the following conditions, please check and give approximate dates or indicate current. If it does not apply, please write N/A.

☐ Arthritis _____
☐ Asthma _____
☐ Blood Pressure Problems _____
☐ Broken Bones _____
☐ Convulsions _____
☐ Diabetes _____
☐ Disabling Headaches _____
☐ Disc Trouble _____
☐ Fainting Spells _____
☐ Heart Problems _____
☐ Osteoporosis _____
☐ Pacemaker Implantation _____
☐ Paralysis or Muscle Weakness _____
☐ Pregnancy _____
☐ Spine Issues _____
☐ Tumor or Cancer _____
☐ Other _____

Please list ALL previous surgeries and the year performed regardless of body part:

_____

_____

_____


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CONSENT FOR TREATMENT

I, the undersigned, do hereby agree and give my consent for Body Gears Physical Therapy to furnish medical care and treatment to myself or _____, considered necessary and proper in diagnosing or treating my physical condition.

Patient/Guardian Signature _____ Date _____

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, the undersigned, 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 Body Gears Physical Therapy.
A photocopy of this assignments to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

Patient/Guardian Signature _____ Date _____

CANCELLATION POLICY

Together, you and your therapist will set your treatment goals and time frames to complete these goals. It is important that you attend all scheduled treatment sessions to achieve the best success. If you must cancel or change an appointment, we request that you give us 24-hours' notice prior to your scheduled appointment time by calling 877-709-1090. There will be a $25.00 cancellation fee that is not reimbursable by your insurance company if we are not given 24-hours' notice. After three cancellations or no-shows, we reserve the right to charge $75.00 per cancellation or no-show, per scheduled appointment. If you are a worker's compensation patient, please be advised that your employer, physician, and rehabilitation nurse/adjustor may be notified of each missed appointment.

I acknowledge that I have read and understand this cancellation policy.

Patient/Guardian Signature _____ Date _____


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