BodyGears
Physical Therapy
Enhancing Human Mechanics

Welcome to Body Gears Physical Therapy

Please fill out the following form, print it, and bring it to your first appointment.

Otherwise, please arrive to your clinic 15 minutes prior to your scheduled appointment.

Note:
This symbol "*" indicates a required field.

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CLIENT INTAKE FORM

Date:____/____/_____

CLIENT INFORMATION

Name*: **Height:** **Weight:**

Address*:

Home*: **Mobile*:** **Work:**

Date of Birth*: **SS#:** **Email*:**

I consent to receiving text message, email and/or phone reminders, and understand I can opt out at any time.

☐ Do not send text reminders ☐ Do not send emails

How did you hear about BGPT? ☐ Self ☐ Friend/Family ☐ Doctor ☐ Employer ☐ Event ☐ Google ☐ Website ☐ Facebook ☐ Other

Name/Title of person who referred you: **Phone:**

Primary Care Physican: **Phone:**

Emergency Contact/ Relationship:

Home: **Mobile:** **Work:**

MEDICAL HISTORY

Do you have/had any of the following medical illnesses/concerns? Please circle YES (Y) or NO (N)

Heart Problems	☐	☐	**Pregnant**	☐	☐	**Smoke/Tobacco Products**	☐	☐	**Seizures**	☐	☐
High Blood Pressure	☐	☐	**Diabetes**	☐	☐	**Asthma**	☐	☐	**HIV/AIDS**	☐	☐
Pacemaker	☐	☐	**Cancer**	☐	☐	**Osteoporosis**	☐	☐	**Stroke**	☐	☐

List all current medications, and include amount/frequency (i.e. Darvocet, 100 mg, every 6 hours):

Please describe your chief physical complaint and (i.e. back pain)*:

How/When it happened (i.e. lifted a box at work, two weeks ago):

Have you had previous therapy for this problem/injury? ☐ Yes ☐ No If yes, was it helpful? ☐ Yes ☐ No

What other surgeries/injuries have you had in the last five years?

Client Rates:
40 minutes = $150
60 minutes = $200
House call = $350

A 24-hour prior notification of all cancellations is required and appreciated so that the appointment time may be used for others in need of therapy.

Client Signature*: _____

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Acknowledgement of Receipt of Notice of Privacy Practices and Release Authorization

I certify that I have received a copy of the Notice of Privacy Practices of Dynamic Physical Therapy, Inc. DBA "Body Gears Physical Therapy" and/or its subsidiaries and affiliates (collectively, "BGPT"). The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of BGPT health care operations. The Notice of Privacy Practices also describes my rights and BGPT's duties with respect to my protected health information. The Notice of Privacy Practices is also posted in the Front Desk area and on the BGPT website at www.bodygears.com.

BGPT reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment or accessing the BGPT website.

By signing this Authorization Form, I understand that I am giving my authorization to BGPT's designated medical record custodians, database custodians, central billing / collections office personnel to use and/or disclose my protected health information (PHI), as described in more detail in the paragraphs below, to the following person(s) or organization(s):

Name of person(s) or organization(s): _____
Street address: _____
City, State, and zip code: _____
Telephone number: _____
Fax number: _____
Relationship to client: _____

If this authorization is for any purpose other than the release of medical records for personal reasons, please state the purpose of the authorization to release PHI below:

_____

I may revoke this authorization at any time by notifying BGPT in writing to Attention Collections Manager, 211 N. Clinton Street, Chicago, IL 60661 of my intent to revoke this authorization. However, I also understand that such a revocation will not have any effect on any information already used or disclosed by BGPT before BGPT received my written notice of revocation. Unless earlier revoked, this authorization will expire on the 180th day of the signing (or as otherwise specified _____).

AUTHORIZATION CONSENT FOR CARE AND TREATMENT

I hereby give my consent to the facility and/or treating physicians and their agents to release all records, including via electronic transmittal, prepared in the course of my treatment, to any entity which provides financial assistance for my health care, including, but not limited to, insurance companies and their agents, self-insured employers or public welfare agencies. I certify that the information given by me in applying for payment under Title XVII of the social security act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare program or its intermediaries or carriers, or to the professional standards review organizations any information needed for this or a related Medicare claim. I understand that by signing this form, records of a confidential nature, such as Social Security Numbers and those for HIV testing, AIDS or AIDS related condition, psychiatric problems or substance abuse, will be released to the entities providing financial assistance for my health care. This release includes disclosing data to local, state, federal, other entities for routine operational purpose of regulatory, legal or contract compliance, accreditation, peer review, quality improvement, continuity of care, or processing appeals for claims denials. I also understand that I may revoke this consent at any time and without revocation and that it will expire one year from this date, or if admitted, one year from the date of discharge. I acknowledge that I have been provided and given the opportunity to review the Facility's Information regarding patient's rights and responsibilities. I hereby authorize BGPT to provide care and treatment under my physician's direction or as allowed under my state's direct access provisions.

_____	_____	_____
Signature of Client or Representative *	**Name of Client or Representative***	**Date***

_____
Witness