BROOKLYN BODY WORKS PHYSICAL THERAPY, P.C.
SPORTS & ORTHOPEDIC REHABILITATION

BROOKLYN BODY WORKS PHYSICAL THERAPY & wellness

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:

ADDRESS:	APT:	CITY:	STATE:	ZIP CODE:

HOME PHONE:	CELL PHONE:	WORK PHONE:

EMAIL ADDRESS:

DATE OF BIRTH:	SEX: ◯ FEMALE ◯ MALE	SOCIAL SECURITY NUMBER:

PREFERRED APPOINTMENT REMINDER METHOD: ◯ PHONE CALL ◯ TEXT MESSAGE

HOW DID YOU HEAR ABOUT OUR OFFICE?

EMPLOYER NAME AND ADDRESS:

REFERRING DOCTOR AND ADDRESS:

EMERGENCY CONTACT:

CONTACT NAME:	PHONE NUMBER:	RELATIONSHIP:

FOR PATIENTS WITH MEDICARE INSURANCE:

DO YOU HAVE A SECONDARY INSURANCE? ◯ NO ◯ YES (PLEASE PROVIDE INSURANCE CARD TO RECEPTIONIST)

BROOKLYN BODY WORKS PHYSICAL THERAPY, PC
202 UNION AVENUE, STE K.
BROOKLYN, NY 11211
P. 718-387-7420 | F. 718-387-7421
ADMIN@BBWPHYSICALTHERAPY.COM

BROOKLYN BODY WORKS PHYSICAL THERAPY & WELLNESS
101 N. 10TH STREET, STE 302
BROOKLYN, NY 11249
P. 718-702-6105 | F. 718-702-8659
WELLNESS@BBWPHYSICALTHERAPY.COM

BROOKLYN BODY WORKS PHYSICAL THERAPY, P.C.
SPORTS & ORTHOPEDIC REHABILITATION

BROOKLYN BODY WORKS PHYSICAL THERAPY & wellness

MEDICAL HISTORY

WHAT ARE YOU BEING TREATED FOR TODAY?

PLEASE DESCRIBE YOUR CURRENT SYMPTOMS:

HAVE YOU HAD SURGERY FOR THIS CONDITION? IF YES, PLEASE DESCRIBE THE PROCEDURE AND DATE OF THE SURGERY.

ARE YOU TAKING ANY MEDICATION FOR THIS CONDITION? IF YES, PLEASE LIST BELOW:

HAVE YOU HAD PHYSICAL THERAPY OR ANY OTHER TREATMENT FOR THIS CONDITION IN THE PAST? PLEASE DESCRIBE BELOW.

WHEN DID YOUR SYMPTOMS OR INJURY FIRST OCCUR? DID THEY ARISE GRADUALLY OR SUDDENLY? PLEASE DESCRIBE BELOW.

WAS YOUR CONDITION RELATED TO A WORK OR CAR ACCIDENT? ◯ NO ◯ YES

RATE YOUR CURRENT PAIN LEVEL: (0 = NO PAIN 10 = EXCRUCIATING PAIN)

0 1 2 3 4 5 6 7 8 9 10

IS YOUR PAIN CONSTANT OR INTERMITTENT? _____

DOES YOUR PAIN FOLLOW A PATTERN WHERE IT IS WORSE IN THE AM OR PM? _____

DOES YOUR PAIN WAKE YOU UP AT NIGHT? ◯ NO ◯ YES

DO YOU HAVE RADIATING PAIN THAT CAN BE DESCRIBED AS BURNING/ ELECTRICAL? ◯ NO ◯ YES

DO YOU HAVE NUMBNESS OR TINGLING IN ONE OR MORE EXTREMITIES? ◯ NO ◯ YES

WHAT ACTIVITIES MAKE YOU PAIN WORSE?

PLEASE DESCRIBE YOUR CURRENT FUNCTIONAL LIMITATIONS. EG: WALKING, STAIRS, GETTING OUT OF BED, RECREATIONAL ACTIVITIES, ECT

CONSENT AND STATEMENT

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Brooklyn Body Works Physical Therapy, PC to furnish the medical care and treatment considered necessary in assessing or treating my physical and mental condition.

BENEFIT ASSIGNMENT/ RELEASE OF INFORMATION

I hereby assign all medical benefits to which I am entitled, including that from Medicare, Medicaid, private insurance and third-party payers to Brooklyn Body Works Physical Therapy, PC. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize BBW to release all information necessary, including Medical Records, to secure payment.

FINANCIAL POLICY STATEMENT

Brooklyn Body Works Physical Therapy will bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill for services rendered. We require that arrangements for payment of your estimated share be made today, this share includes but are not limited to copayments, co-insurance, and deductibles. We accept cash, personal checks (with matching ID) and money orders/ cashier's checks only. If your insurance carrier does not remit payment within 90 days, we reserve the right to collect balance in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company.

If your insurance company makes any payments directly to you for services rendered by us, you recognize an obligation to promptly remit the same to Brooklyn Body Works Physical Therapy, PC.

For those patients filing a claim under New York State No Fault or Workers Compensation Law, be advised that if you claim W/C or No Fault benefits and are subsequently denied such benefits, you are responsible for the usual amount of charges for services rendered to you.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed to *Brooklyn Body Works Physical Therapy,* including court costs, collection agency fees and attorney fees.

ESTIMATED RESPONSIBILITY PER VISIT: _____

NOTE: ESTIMATED COVERAGE INFORMATION IS PROVIDED AS A COURTESY TO OUR PATIENTS BUT IS NOT INTENDED TO RELEASE THEM FROM TOTAL RESPONSIBILITY FOR THEIR ACCOUNT BALANCE. WE VERIFY YOUR BENEFITS PRIOR TO YOUR INITIAL VISIT BUT FINAL RESPONSIBILITY IS INDICATED BY YOUR INSURANCE PLAN WHEN CLAIMS ARE PROCESSED.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT

PATIENT/ GUARDIAN SIGNATURE: _____ DATE: _____

BBW PT REPRESENTATIVE: _____ DATE: _____

BROOKLYN BODY WORKS PHYSICAL THERAPY, P.C.
SPORTS & ORTHOPEDIC REHABILITATION

BROOKLYN BODY WORKS PHYSICAL THERAPY & wellness

PATIENT AGREEMENT

- New York State law requires that patients obtain a written prescription before initiating treatment by a licensed physical therapist if they are to use their insurance benefits to pay for treatment.
- Patient is responsible to inform BROOKLYN BODY WORKS PHYSICAL THERAPY (BBWPT) of any changes in insurance coverage prior to that change. If the patient fails to inform BBWPT of a change in insurance coverage, the patient will be held responsible for any unpaid claims related to a lapse or change in benefits. This includes MEDICARE patients who are under Home Health Care or those who choose a Medicare Advantage plan.
- The patient is responsible for all copayments and deductibles prior to their appointment.
- All visits are by appointment only and generally last about an hour.
- IT IS THE PATIENT'S RESPONSIBILITY TO CONFIRM ALL APPOINTMENTS. Our office sends courtesy text or email reminders. If a patient does not confirm their appointment, our office reserves the right to void their appointment and offer it to a waitlisted patient.
- We request that patients call if they are going to be late. If a patient arrives 15 minutes after their scheduled time, BBWPT reserves the right to cancel the appointment. Remember, this is your scheduled time and the therapist's time is just as valuable as your own time.
- WE REQUEST 24 HOURS NOTIFICATION IN THE EVENT OF A CANCELED APPOINTMENT.
  If appropriate notice is not given a charge of $75 will be assessed to the patient. We understand that sometimes last-minute cancellations are unavoidable. Individual circumstances may be discussed with the office manager.
- Should a patient cancel or no-show repeatedly within the course of treatment, the patient may be taken off the schedule and may forfeit all future appointments. **Workman's compensation and no-fault patients also risk losing their benefits for physical therapy services and/or may face other legal consequences for non-compliance with care.**

- ☐ I understand that I am responsible for my deductible and copayments.
- ☐ I hereby state that I am not eligible for NYS No-fault or NYS Workman's Compensation Insurance.
- ☐ I agree to inform BBWPT of any changes in my insurance coverage or benefits prior to the effective date of these changes.
- ☐ I understand that I am responsible for my appointments and if I fail to give appropriate notice, I am responsible for any late cancellation or no-show fees.

I AGREE TO TREATMENT ON THE ABOVE TERMS.

SIGNATURE: _____ DATE: _____

PRINT NAME: _____

HIPAA AWARENESS CONTRACT

With my permission, **BROOKLYN BODY WORKS PHYSICAL THERAPY PC**, (THE PRACTICE) may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to **BROOKLYN BODYWORKS PHYSICAL THERAPY**'S Notice of Privacy Practices for a more complete description of such uses and disclosures.

A copy of the Notice of Privacy Practices was made available to me prior to signing this consent. The Practice reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of **BROOKLYN BODY WORKS PHYSICAL THERAPY PC** may call my home or other designated locations and leave a message on voicemail, or in person, in reference to any items that may assist The Practice in carrying out TPO, such as appointment reminders, insurance matters and any information pertaining to billing/collections or my clinical care.

With my permission, the office of **BROOKLYN BODY WORKS PHYSICAL THERAPY PC** may mail to my home or other designated location any items that assist The Practice in carrying out TPO such as appointment reminder cards and patient statements as long as they are marked PERSONAL AND CONFIDENTIAL. I have the right to request that The Practice restrict how it uses or discloses my Personal Health Information to carry out TPO. However, The Practice is not required to agree with my requested restrictions, though if it does so, it is bound by this agreement.

By signing this agreement, I am allowing **BROOKLYN BODY WORKS PHYSICAL THERAPY PC** to use and disclose my PHI for TPO.

I may revoke my consent in writing except to the extent that The Practice has already made disclosures in reliance upon my prior consent.

SIGNATURE: _____ DATE:_____