

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

PATIENT REGISTRATION FORM

NAME First Middle Last DATE OF BIRTH
SEX: M F
MARITAL STATUS
SS#

ADDRESS Street City State Zip

HOME # WORK# CELL#

E-MAIL OCCUPATION EMPLOYER

Primary Care Physician Referring Physician

PRIMARY INSURANCE COMPANY
Company Name
Are you the policy holder? Y N If No, complete below
Policy Holder Name:
Address, if different
Employer
Work # Home #
Sex: M F SS #:
Birthdate RELATIONSHIP

SECONDARY INSURANCE COMPANY
Company Name
Are you the policy holder? Y N If No, complete below
Policy Holder Name:
Address, if different
Employer
Work # Home #
Sex: M F SS #:
Birthdate RELATIONSHIP

Do we have your permission to:
Leave a message on your answering machine at home?
Leave a message at your place of employment/ work voice mail?
Send you a message via email?
Discuss your medical condition with any member of your household?

Preferred phone # to contact you: Home Work Cell
Who should we contact in an emergency? Relationship Phone #

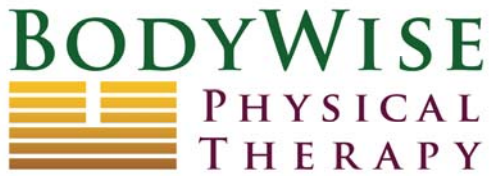
ASSINGMENT OF BENEFITS / INFORMATION RELEASE / AUTHORIZATION TO TREAT

I authorize payment of medical benefits to BodyWise Physical Therapy & Acupuncture, LLC (BWPT) for any services furnished. I understand that I am financially responsible for any amount not covered by my insurance carrier or any amount that Medicare allows to be collected from me. Charges and co-pays are due at the time of service. A fee of \$60.00 may be assessed for a missed appointment or late cancellation. If my account is turned over to a collection agency, I will be responsible for all collection fees incurred. I authorize you to release to my insurance company, Medicare (as applicable), other payer or any of their agents, any information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purposes of evaluating and administering claims of benefits.

I also authorize BWPT's staff to perform the treatments or procedures approved by my referring physician. I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any medical treatment or procedure.

I have been given the opportunity to review our Notice of Privacy and Disclosure Practices.

Signature of Patient, Parent or Guardian (if patient is under age 18) 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 four 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?
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_



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.

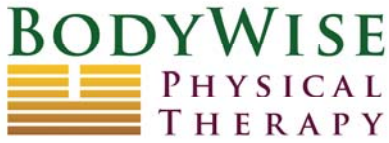
**To receive additional information or report a problem,** you may contact our clinic administrator at 240-841-2639. If you believe your privacy rights have been violated, you have the right to file a complaint with us by contacting our clinic administrator and/or with the U.S. Secretary of Health and 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**

If you are unable to keep your appointment, kindly provide 24 hours notice to avoid being assessed a \$60.00 cancellation fee. Please sign below indicating that you are aware of this policy.

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

**LATENESS POLICY**

Please be advised that if you are more than 15 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. If we are unable to see you, it will be considered a missed appointment and you may be charged a \$60.00 fee. Please sign below that you are aware of this policy.

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

**PERFUME/COLOGNE POLICY**

Our staff is prohibited from wearing perfume or cologne when working, which can cause headaches and breathing difficulties for people with sensitivities to fragrances. We ask that you please refrain from wearing perfume, scented oils, or cologne to your appointments for the health and well-being of other patients and staff.

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

*We thank you for your cooperation and integrity.*

## What can I do before my first visit?

Make a list of any questions that you might have, so that you can make the best use of your time with your physical therapist.

Write down any symptoms you've been having and for how long. If you have more than one symptom, begin with the one that is the most bothersome to you.

Make specific notes about your symptoms. For example, is your pain or other symptom:

- Better or worse with certain activities or movements or with certain positions, such as sitting or standing?
- More noticeable at certain times of day?
- Relieved or made worse by resting?

Write down key information about your medical history, even if it seems unrelated to the condition for which you are seeing the physical therapist.

Make a list of all prescription and over-the-counter medications, vitamins, and supplements that you are taking.

Make a note of any important personal information, including recent stressful events in your life.

Write down and describe any injuries, incidents, or environmental factors that you believe might have contributed to your condition.

Make a list of any medical conditions of your parents or siblings.

Consider taking a family member or trusted friend along to help you remember details from your own health history and to take notes about what is discussed during your visit.

Make sure you can see and hear as well as possible. If you wear glasses, take them with you. If you use a hearing aid, make certain that it is working well, and wear it. Tell your physical therapist and clinic staff if you have a hard time seeing or hearing. For example, you may want to say, "I have difficulty hearing. It's helpful to me when you speak slowly."

If available, bring any lab or diagnostic reports from other health care professionals who have treated you for your current condition.

Bring a list of the names of your physician and other health care professionals that you would like your physical therapist to contact regarding your evaluation and your progress.