Welcome to
Better Bodies Physical Therapy

Personal Information

Full Legal Name: ______________________________ Preferred Name: ______________
First *MI* *Last*

Mailing Address: ______________________________

City: ______________ State: _____ ZIP + 4: ____________ SSN: ____________

Male / Female *(Circle One)* Status *(circle one)*: Single / Married / Widowed / Divorced / Legally Separated / Minor

Primary Language (e.g. English / Spanish): ____________ Ethnicity *(circle one)*: Hispanic or Latino / Not Hispanic or Latino

Race *(circle one)*: American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or Other Pacific Islander / White

Date of Birth : ____________

Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________ ext ______

May we text appointment reminders to you? *(circle one)* Yes / No If Yes, who is your cell carrier? ____________

When we need to call you, what are your Primary and Secondary Phone Preferences (e.g. home, cell, etc.)? 1) ________ 2) ________

Overall, how do you prefer that we contact you? If Phone, please note which phone. (Text *is* an option.) ____________

Email Address: ______________________________

How did you hear about us? ______________________________

Employer: ____________ Occupation: ____________

Do you have children? *(circle one)* Yes / No If Yes, how many? ______

Current Height: ______ Current Weight: ______ Do you smoke? *(circle one)* Yes / No / Former Smoker

Have you had any falls? *(circle one)* Yes / No

If so, when: ____________ Were you injured? *(circle one)* Yes / No

Emergency Contact

Name ____________ Relationship: ____________ Phone: ____________

Who is your Medical Doctor (PCP)? ____________ Doctor's Phone: ____________

______ (Initials) **By initialing here, I authorize Better Bodies Physical Therapy to send my Medical Doctor (PCP) the evaluation and progress notes.**

PLEASE CONTINUE TO NEXT PAGE.

Insurance Information **(If you have insurance, we must copy your current card and photo ID.)**

Insurance Company: ______________________ Member ID #: ______________________ Group #: ______________________

Name of Insured (*if NOT you*): ______________________________________ Relationship to Insured: ____________________

Insured's DOB (*if NOT you*): ______________________ Insured's Employer: ____

Is this a workman's comp case? Y / N

If yes, who is your case manager?: ___________________________________ Telephone number:______________________

________ **(Initials) I fully understand that I am solely responsible for any balance not paid by the insurance company. Co-payment or coinsurance is due at time of service.**

OR

________ **(Initials) I have no insurance coverage and fully understand that I am solely responsible for the balance in full at time of service.**

Reason for Visit

The reason for this visit is the result of *(circle one)*: Work / Sports / Auto / Trauma / Chronic

Explain what happened: ____

____

When did this condition begin? ______________________

Is this condition getting worse *(circle one)*? Yes / No / Constant / Comes and Goes

Is this condition interfering with your *(circle one)* Work / Sleep / Daily Routine / None

If Yes, please explain: ____

Have you been treated by a Medical Physician for this condition *(circle one)*? Yes / No

If Yes, by whom or where were you treated? ____

Have you ever been treated by a physical therapist *(circle one)*? Yes / No

If Yes, by whom? _________________________________

If Yes, when were you last treated? ___________________________

Is there anything else you feel we should know? ____

Health History

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

__Pneumonia
__Rheumatic Fever
__Polio
__Tuberculosis
__Whooping Cough
__Anemia
__Measles

__Mumps
__Small Pox
__Chicken Pox
__Diabetes
__Cancer
__Heart Disease
__Thyroid

__Influenza
__Pleurisy
__Arthritis
__Epilepsy
__Mental Disorders
__Lumbago
__Eczema

INTAKE
__White Sugar
__Coffee
__Tea
__Alcohol
__Cigarettes

Have you been tested HIV positive? Yes____ No____

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS, *NOT INCLUDING* YOUR PRESENTING COMPLAINT (the reason you are here today).

MUSCULO-SKELETAL
__Low Back Pain
__Pain Between Shoulders
__Neck Pain
__Arm Pain
__Joint Pain/Stiffness
__Walking Problems
__Difficult Chewing/ Clicking Jaw
__General Stiffness

NERVOUS SYSTEM
__Nervous
__Numbness
__Paralysis
__Forgetfulness
__Confusion/Depression
__Fainting
__Convulsions
__Cold/Tingling Extremities
__Stress
__Dizziness

GENERAL
__Fatigue
__Allergies
__Loss of Sleep
__Fever
__Headaches

EENT
__Vision Problems
__Dental Problems
__Sore Throat
__Ear Aches
__Hearing Difficulty
__Stuffed Nose

GASTROINTESTINAL
__Poor/Excessive Appetite
__Excessive Thirst
__Frequent Nausea
__Vomiting
__Diarrhea
__Constipation
__Hemorrhoids

__Liver Problems
__Gall Bladder Problems
__Weight Trouble
__Abdominal Cramps
__Gas/Bloating After Meals
__Heartburn
__Black/Bloody Stool
__Colitis

C-V-R
__Chest Pain

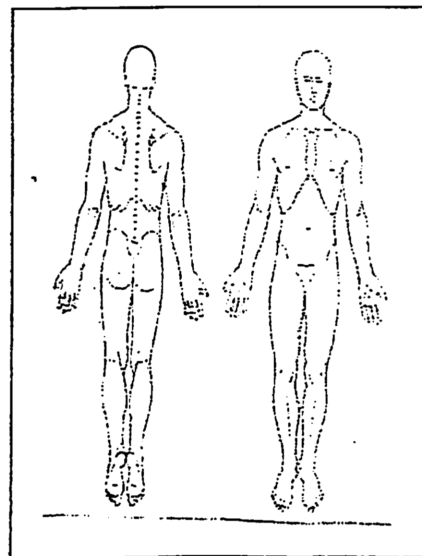
__Short Breath
__Blood Pressure Problems
__Irregular Heartbeat
__Heart Problems
__Lung Problems/Congestion
__Varicose Veins
__Ankle Swelling
__Stroke

MALE/FEMALE
__Menstrual Cramps
__Menstrual Irregularity
__Vaginal Pain/Infection
__Breast Pain/Lumps
__Prostate/Sexual Dysfunction
Other Problems________________

FEMALES ONLY
When was your last period?____________
Are you pregnant? Yes__ No__ Maybe__

GENITO-URINARY
__Bladder Trouble
__Painful/Excessive Urination
__Discolored Urine

FAMILY HISTORY
The following members have a same or similar condition as I do:
__Mother __Father
__Brother __Sister
__Spouse __Child



Please outline on the diagram the area of your discomfort.

Health History Continued

Please list any other serious medical condition(s) you have or ever had: ______________________________

____

Please list anything to which you may be allergic: ______________________________

____

List previous surgeries/treatments with dates: ______________________________

____

List any past serious accidents with dates: ______________________________

____

Are you taking any of the following medications? ___Nerve Pills ___Pain Killers (including aspirin)
___Muscle Relaxers ____Stimulants ____Blood Thinners ____Tranquilizers ____Insulin
___Other (s) ______________________________

Do you: Take Supplements or Vitamins? ___Yes ___No Exercise? ___Yes ___No

Are you wearing: ___ Heel Lifts ____Sole Lifts ____Inner Soles ___Arch Supports

Please Read and Sign

*We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
*I authorize the staff to perform any necessary services needed during diagnosis and treatment. I authorize the provider and or managed care organization to release any information required to process insurance claims.
*I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand that I am solely responsible for any balance not paid by my insurance company (if offered at this office).
*Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collections agency fees, and any other expenses incurred in collecting your account.
*I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any further changes to the information I have provided.

Signature ______________________________ Date: ________/________/________
__Adult Patient __Parent or Guardian __Spouse

Medications List

Patient Name: ______________________________ Date: _______________

Please include **ALL** prescription, over the counter, herbal, and vitamin/mineral/dietary (Nutritional) supplements.

Name	Dosage	Frequency	Route of Administration

Better Bodies Physical Therapy, PLLC
Chiropractic, Physical Therapy and Massage
Dr. Jeannette Pfeffer
1570 Early Settlers Rd.
N. Chesterfield, VA 23235

Standard Authorization Of Use And Disclosure Of Protected Health Information

Information to be used or disclosed:
The information covered by this authorization includes: Your name, accumulated health records, examination scans and x-rays, and any information in your patient file or travel card.

Persons authorized to use or disclose information:
Better Bodies Physical Therapy and current employees of Better Bodies Physical Therapy.

Persons to whom information may be disclosed:
Office employees at minimal degree when deemed necessary, your private physician, hospitals, attorneys if authorized or subpoenaed, referral and welcome boards in our office, birthday and holiday cards, referral; and thank you letters, testimonial book (including your picture if authorized), insurance carriers, any outside collection services retained by Better Bodies Physical Therapy (electronic claims service).

Expiration date of authorization:
This authorization is effective as of your signature date and is ongoing until you revoke or terminate this authorization by submitting a written revocation to Better Bodies Physical Therapy.

Potential for re-disclosure:
Information that is disclosed under this authorization may be disclosed again by the person or organization, which revoked or terminated initial authorization. Re-disclosure must be in writing.

Name of Patient: ____

Signature of Patient: ______________________________ Date: ____________

Signature of patient representative: ______________________ Date: ____________

Relationship of patient representative to patient: ____________________________

Better Bodies Physical Therapy, PLLC
Chiropractic, Physical Therapy and Massage
Dr. Jeannette Pfeffer
1570 Early Settlers Rd.
N. Chesterfield, VA 23235

Release of Protected Health Information

I give permission to Better Bodies Physical Therapy to discuss medical information, release test/x-ray results, appointment/times, and payment issues to the following people:

Name: ______________________________ Date: ______________

Name: ______________________________ Date: ______________

Name: ______________________________ Date: ______________

Name: ______________________________ Date: ______________

Name: ______________________________ Date: ______________

Patient Signature: ______________________________ Date: ______________

**This notice will remain in effect until notified in writing by the above patient.*

Office Policies

We believe that a clear definition of our office policy will allow both you, the patient; and us, Better Bodies Physical Therapy, to concentrate on the bog issues — regaining and maintaining your health.

Appointments

Multiple appointments are arranged for convenience to all patients. Should it be impossible to keep an appointment, we do expect notice as soon as possible. Regardless of how many appointments ore scheduled for you each week, please keep in mind that it is the frequency of your visits and not the days that are important. If you are unable to keep your appointment for any reason, please call immediately to reschedule your visit.

If you miss an appointment, you may be assessed a $45 missed appointment fee.

If you are late for your appointment, your appointment may need to be rescheduled or services may need to be reduced (example: reduced therapy time)

Financial Policy

All fees are dependent upon services rendered and are ultimately the responsibility pr the patient regardless of whether or not this office accepts insurance assignment for payment of bills. If your insurance is qualified by our insurance coordinator you may be extended the courtesy of assigning insurance benefits directly to the office by thereby reducing your out of pocket expenses.
All durable medical supplies are payable by the patient when supplies are received.

Any balance past due 90 days will be sent to our collection agency and all costs of collection, including attorney's fees, equal to 1/3 of all sums due and payable will be added to your account. Also we will assess a FINANCE CHARGE equal to 1% per month (18% annual) on the amount you owe at the beginning of the billing cycle, less than any payments and credits received during the billing cycle.

It is the goal of this office to provide you with the finest quality chiropractic care available. If you have any questions with regard to your healthcare or any of our office policies, please let us know, we welcome your referrals and look forward to a doctor-patient relationship that works for our mutual benefit.

By signing I acknowledge that I have read the preceding information and understand my responsibilities and those of the office.

____

Printed name of Patient or Legal Guardian

____

Patient Signature **Date**

Insurance Assignments

It is the policy of this office to extend to our patients the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out of pocket expense.

1) Our office will qualify your insurance coverage in an effort to help you determine exactly what chiropractic coverage is available to you under your policy and if it will be accepted as payment toward your bill.

2) For your initial visit, all deductible payments must be made prior to insurance submittal.

3) Deductibles, co-payments and payment plan amounts are expected at the time of service or at the beginning or end of each week.

4) From time to time we may experience difficulty in collecting from your insurance company and since insurance assignment is a courtesy, it may be terminated at any time. We will, of course, give you ample notice and ask that you act in your own behalf with your insurance company.

5) This office does not promise that your insurance company will pay for the usual and customary charges of this office, nor will this office enter into a dispute with an insurance company over reimbursement. We cannot alter or guarantee your insurance company.

6) Should you receive payment from the insurance company as a result of insurance forms summated from this office, you will promptly submit such payments to this office within a week to cover any outstanding balance on your account.

7) Should your insurance reflect, dispute or not cover the total amounts of charges submitted, YOU will pay any outstanding balance within 30 days of verbal or written notification. It will be your responsibility to pursue reimbursement from the insurance company.

8) It is understood and agreed that you, the patient, are responsible for perfecting and following up on any insurance claims. If your account is turned over to an outside party for collection, the undersigned agrees to pay all cost of collection, including attorney's fees, equal to 1/3 of all sums due and payable. If the unpaid balance of your accounts not paid in full within 90 days of the date shown on your monthly statement, we will assess a finance charge equal to 1% per month (18% annual) on the amount you owe at the beginning of the billing-cycle, less any payments and credits received during the billing cycle.

I have read the preceding information and understand my responsibilities and those of the office. I hereby assign any and all insurance benefits to Better Bodies Physical Therapy and authorize Better Bodies Physical Therapy to act as agent in helping obtain payment from the indicated insurance companies.

____

Printed name of Patient or Legal Guardian

____

Patient Signature Date

PATIENTS' RIGHTS AND RESPONSIBILITIES

STATEMENT OF RIGHTS

- Patients have the right to be treated with dignity and respect.
- Patients have the right to fair treatment regardless of race, religion, gender, ethnicity, age, disability or source of payment.
- Patients have the right to have their treatment and other information kept private.
- Only in life-threatening situations or if required, can records be released without a signed consent from patients.
- Patients have the right to information from staff/providers in a language they can understand.
- Patients have the right to an easy-to-understand explanation of their condition and treatment.
- Patients have the right to know all about their treatment choices regardless of cost coverage.
- Patients have the right to get information about services offered by their providers and patient role in the treatment process.
- Patients have the right to know the clinical guidelines used in providing and/or managing their care.
- Patients have the right to provide suggestions on office policies and procedures.
- Patients have the right to complain and to know about the complaint, grievance and appeals process.
- Patients have the right to know about State and Federal laws governing their rights and responsibilities.
- Patients have the right to participate in the formation of their plan of care.

STATEMENT OF RESPONSIBILITIES

- Patients are responsible for providing their medical provider with information needed to deliver quality care.
- Patients are responsible for informing their provider when/if their treatment plan is no longer effective.
- Patients are responsible to follow their treatment plans and to inform their provider of any changes to the treatment plan made by other providers including any changes in their medications.
- Patients are responsible for reviewing their care and treatment plans continuously and reporting effectiveness or ineffectiveness of the care plan to their provider.
- Patients are responsible for treating those giving them care with dignity and respect.
- Patients should not be involved in any conscious behavior that could harm the lives of their provider, office staff or other patients.
- Patients are responsible for keeping their appointments, arriving on time and notifying the office of any cancellations at least 24 hours prior to the appointment.
- Patients are responsible for addressing questions about their care to their provider and ensure understanding of their care and their role in the treatment process.
- Patients are responsible for notifying their provider of any concerns regarding payment or insurance coverages.