

SECONDARY INSURANCE INFORMATION

(PLEASE COMPLETE THIS SECTION IN FULL; WE WILL COPY FRONT / BACK OF INSURANCE CARD)

INSURANCE CO _____

* PRIMARY POLICY HOLDER'S NAME _____ SSN# _____

DOB _____ EMPLOYER _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ - _____

HOME PHONE (____) _____ - _____

CELL PHONE (____) _____ - _____

WORK PHONE (____) _____ - _____

E-MAIL ADDRESS _____

(IF THE PATIENT IS A MINOR)

MOTHER'S NAME _____

FATHER'S NAME _____

SSN# _____

SSN# _____

EMPLOYER _____

EMPLOYER _____

PHONE (____) _____ - _____

PHONE (____) _____ - _____

OCCUPATION _____

OCCUPATION _____

RELEASE OF MEDICAL INFORMATION _____ initials

I authorize EQUILIBRIUM Balance Performance Center, PT, Inc to release medical records concerning my self / son / daughter / other dependent to any physician, hospital, or agency involved in the care of the patient listed.

ASSIGNMENT OF MEDICAL BENEFITS _____ initials

I authorize my insurance carrier to assign medical benefits to EQUILIBRIUM Balance Performance Center, PT, Inc. I also authorize release of medical information necessary to process all medical insurance claims.

PAYMENT POLICY _____ initials

Co-payments are due at the time services are received. We accept cash and check only at this time. All medical services provided are directly charged to the patient or responsible party. If our clinic is contracted with your insurance carrier, we will accept their negotiated rate for the charges billed. However, you will be responsible for any balance deemed patient responsibility / non-payable / non-covered by your insurance company and billed accordingly. Payment is expected in full upon receipt of statement or payment arrangements must be made with our billing office.

CANCELATION POLICY _____ initials

Our office requires that if an appointment needs to be cancelled, we receive notice no later than 5pm on the previous business day prior to your scheduled appointment. Please note, our business days are Tuesday through Friday. Cancellations for Tuesday must be received by 5PM on the preceding Friday. Cancellations and no show fees are the patient's responsibility and will not be billed to your insurance. Fee payments are due on or before your next appointment. **I, the patient, agree to pay a \$50.00 fee for each late cancellation and no show appointment.**

REFERRAL POLICY _____ initials

I understand it is my responsibility to obtain a prescription from my referring physician's office to receive therapy services. Failure to do so will result in charges being billed in full directly to myself. In addition, all therapy services will be placed on hold until the physician's prescription for therapy services is received.

I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION, PAYMENT POLICIES AND CLINIC POLICIES:

X _____
SIGNATURE OF RESPONSIBLE PARTY

X _____
DATE READ AND SIGNED

PATIENT QUESTIONNAIRE**DIAGNOSIS:** (reason you are here): _____**Are you currently being seen by any of the following?**
 Physical Therapist Speech Therapist Occupational Therapist Psychiatrist/Psychologist

If you are seeing any of the above, please describe the reason: _____

Have you had therapy for this recent illness? Yes No**If you answered yes, please explain where and when, and the outcome of the therapy:** _____**INITIAL ONSET DATE OF SYMPTOMS/EXACERBATION:** ____ / ____ / ____**PRIMARY SYMPTOMS:** _____**WHAT CAUSED YOUR SYMPTOM ONSET/EXACERBATION:** _____**MEDICAL HISTORY RELATED TO YOUR CURRENT SYMPTOMS:** _____**SEVERITY OF SYMPTOMS: (rated 0-10) Severity of Pain** ____ / 10**WHAT AGGRAVATES YOUR SYMPTOMS:** _____**ACTIVITIES RESTRICTED DUE TO CONDITION:** _____**OTHER MEDICAL HISTORY:** Have you had or do you suffer from: (Check all that apply)

- Heart problems _____
 Diabetes
 Stroke/Neurological
 Multiple Sclerosis
 Parkinson's Disease
 Seizures/Convulsions
 Kidney disease
 Cancer
 Life threatening infection
 Cardiac/heart disease
 Fibromyalgia
 Rheumatoid Arthritis
 Depression
 Do you drink alcohol? Yes No how much? _____ Use tobacco? Yes No packs/day _____
 Use recreational drugs? Have a dependency on prescription drugs? Yes No how much? _____
 Recent flu/Virus (please specify): _____

 Musculoskeletal conditions – (please list) _____**MEDICATION**

Are you currently taking any medication for your condition? _____

PREVIOUS LEVEL OF FUNCTION

Describe: _____

CURRENT LEVEL OF FUNCTION

Describe: _____