.new beginning therapeutic services llc.
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Patient Information

Patient Last Name:_____First Name:_____MI: _____

Today's Date:_____Birth Date:_____

Street Address: _____

City:_____ State:_____Zip:_____

Home Phone: (_____) _____Mobile Phone: (_____) _____

Date of Injury:_____ ☐ Employment Related ☐ Automobile Related

Have you received any therapy within the last calendar year? _____

Marital Status: ☐ Single ☐ Married ☐ Divorced Patient Sex: ☐ M ☐ F

Employment Status: ☐ Employed ☐ F/T Student ☐ Retired Occupation: _____

Bill to Information:_____

Street Address:_____

City:_____State:_____Zip:_____

Employer Contact Phone: (_____) _____Contact Name: _____

Primary Care Physician:_____Referring Physician: _____

Emergency Contact:_____ Phone: _____

Patient Medical History

Prescription Medications: _____

Surgical History: _____

Have you received physical therapy treatment this calendar year? ☐ Yes ☐ No

Please check all that you have ever had:

□ Arthritis
□ Broken Bones/Fractures
□ Cancer
□ Diabetes
□ Heart Problems
□ High Blood Pressure
□ Lung Problems
□ Osteoporosis
□ Seizures
□ Stroke
□ Head Injury
□ Multiple Sclerosis
□ Muscular Dystrophy
□ Parkinson's Disease
Other: _____

Are your having any of these symptoms?

□ Chest Pains
□ Coordination Problems
□ Difficulty Sleeping
□ Headaches
□ Loss of Balance
□ Pain at Night
□ Visual Problems
□ Weakness

Are you pregnant? □ Yes □ No

History of Current Problems

What is your condition/injury: _____

When did the problem(s) begin? _____

What happened? _____

Have you had the problem(s) before? □ Yes □ No

What makes the problem(s) worse? _____

What makes the problem(s) better? _____

Current Limitations: (check all that apply)

□ Difficulty with Walking
□ Difficulty with Stairs
□ Difficulty with Walking on Rough Ground
□ Difficulty with Bathing, Dressing, Eating
□ Difficulty with Chores, Shopping, Driving
□ Difficulty with Work, School
□ Difficulty with Recreation Activities

I HEREBY CERTIFY THAT ALL INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE, AND I AM RESPONSIBLE FOR ALL CHARGES INCURRED FOR THESE SERVICES. LATE PAMENTS MAY BE SUBJECT TO 1.5% FINANCE CHARGES. I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIM AND AUTHORIZE MY INSURANCE COMPANY TO PAY new beginning therapeutic services llc DIRECTLY FOR SERVICES RENDERED. I will advise the therapist if there are any changes in my physical condition that would alter my response to any of the questions on this form.

Last Name:_____First Name:_____Date of Birth: _____

Patient Signature:_____Today's Date: _____

NBTS ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I understand that New Beginning Therapeutic Services, LLC (referred to below as "the clinic") will use and disclose **health information** about me in the course of providing physical therapy care to me.

I understand that my **health information** may include information both created and received by the clinic, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatment, procedures, prescriptions, and similar health-related information.

I understand that the clinic is permitted to **use and disclose** my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to/or consult and coordinate with other healthcare providers in the course of my treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills claims and other related information to insurance companies or others who may be responsible to pay for some or all of my healthcare; and
- Perform various office, administrative, and business functions that support the clinic's ability to provide me with appropriate care and arrange for payment.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request and that a copy of a summary of the most current version of the clinic's Notices of Privacy Practices in effect will be posted in waiting/reception area.

I understand that the Notice of Privacy Practices describes how I can exercise my right to ask that some or all of my health information not be used or disclosed, and I understand that the clinic is not required by law to agree to such requests.

By signing below, I agree that I have received or been offered a copy of this clinic's Notice of Privacy Practices.

By:_____ Date: _____
(Patient)

-or-

By:_____ Date: _____
(Patient representative)
Description of Representative's Authority: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of the Notice of Privacy Practices, but acknowledgement could not be obtained because:

□ individual refused to sign.
□ communication barriers prohibited obtaining the acknowledgement.
□ an emergency situation prevented us from obtaining acknowledgement.
□ other (please specify)_____