***.new beginning*** therapeutic services llc.

**O f f i c e : 706 - 253 - N B T S ( 6 2 8 7 )** ۰ **f a x : 1 - 888 - 557 - 0 9 3 8**

**e m a i l : i n f o @ n b t s . u s** ۰ **3 7 1 N o a h D r i v e .** ۰ **S u i t e 1 0 2** ۰ **J a s p e r , G e o r g i a 3 0 1 4 3**

**Patient Information**

Patient Last Name: First Name: MI:

Today’s Date: \_\_\_\_\_\_ Birth Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address:

City: \_ State: Zip:

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Contact Method: ⁪ Phone ⁪ Email

Home Phone: ( ) \_ Mobile Phone: ( ) \_

Date of Injury: ⁪ Employment Related ⁪ Automobile Related

Have you received any therapy within the last calendar year?

Are you currently receiving Home Health or Hospice services? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: ⁪ Single ⁪ Married ⁪ Divorced Patient Sex: ⁪ M ⁪ **F**

Employment Status: ⁪ Employed ⁪ F/T Student ⁪ Retired Occupation:

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

Have you had any falls in the last year? ⁪ Yes ⁪ No If yes, how many? \_\_\_\_\_\_\_\_\_\_\_\_

Are you Right or Left handed? Please circle one: Left Right

Please check all that you have ever had:

* Arthritis
* Brain Injury/Concussion
* Cancer
* COPD
* Diabetes
* Heart Problems
* Headaches/Migraines
* Osteoporosis
* Seizures
* Stroke
* 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 is your current pain level on a scale of 0-10? 0 being no pain \_\_\_\_\_

What is your pain level at the worst? \_\_\_\_\_ What is your pain level at best? \_\_\_\_\_\_

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: (Patient)

-or-

By: (Patient representative)

Date:

Date:

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)

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**Missed Appointment and/or “NO SHOW” POLICY**

While we make every effort to keep our patient aware of your appointments, it is your responsibility to remember your appointments. If you cancel less than 24 hours in advance that is considered a missed appointment/no show.

Established patients will be charged a $30.00 fee on ALL no show or cancellation without a 24-hour advance notice. After three (3) missed appointments, the practice may at its discretion choose to discontinue your care.

Please arrive on time for your appointment. Time for your appointment has been arranged for you. If you arrive late your session may be shortened in order to accommodate others whose appointments follow yours. Full payment for your session will be expected.

IF YOU DO NOT APPEAR FOR YOUR APPOINTMENT WITHOUT CALLING YOU WILL BE CHARGED A $30.00 NO SHOW FEE FOR YOUR SESSION. WE FREQUENTLY HAVE A WAITING LIST AND CAN FILL SAME DAY, EVEN LAST MINUTE CANCELLATIONS!

I (PLEASE PRINT)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the undersigned, UNDERSTAND THIS CANCELLATION, " NO SHOW" POLICY AND AGREE TO TERMS ABOVE.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_