



Client Information Sheet

Date _____

Name	Date of Birth:		
Home Address	gender: M F		
City State Zip			
Phone: Home	Work	Mobile	
Email	(check preferred contact method)		
Employment			
Emergency contact: Name			phone #:
Primary care physician:			
Referring physician & date of last visit			

What is your primary reason for utilizing physical therapy?

Was your injury caused by a: ____ Motor Vehicle Accident or ____ Work Injury

What other sources of care have you used for your current condition?

Are you currently taking any medications (prescription, over the counter, herbal or supplements)? If yes, please list medications and dosage.

Have you sought medical care for a similar problem or any other musculoskeletal pain problem in the last 3 years?

Have you had any surgeries? If so, when and what?

How did you find out about the services of Balanced Physical Therapy?

Please complete the backside of this form also

For Balanced Physical Therapy use only:

Service Location: Fitness World, Balanced Movement Studio

ICD-9 Diagnosis codes & descriptions: _____

____ Info sent to AMS ____ Info entered in client database

Cash at Service ____ Insurance Filing ____ Co-pay due at service ____

other arrangements:



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Continued from front:

What are your goals for working together and what time frames do you believe are reasonable to accomplish these goals?

Insurance & Fees

You may either pay for services at each visit or have Balanced Physical Therapy seek payment from your insurance company. If BPT is filing for payment from your insurance company, a copy of your insurance card is required. We will assist you in determining the extent of insurance coverage, but we advise that you verify coverage information with your insurance company. If BPT is filing insurance for you, you may be contacted by Anne Marie Schneider for additional information regarding your insurance claims.

I understand that I am responsible for payment for services provided including any amount that is not paid by my insurance company.

Sign: _____ Date: _____

Release of Medical Records

I, _____ hereby authorize the release of related medical records to Balanced Physical Therapy, LLC. I agree that any records released to or created by Balanced Physical Therapy, LLC will be held in confidence by unless I furnish written request for their release. I also consent to the release of medical records to any third parties who may be paying for the services rendered.

Sign: _____ Date: _____

Cancellation / No Show policy

Balanced Physical Therapy reserves the right to charge a \$20 fee for appointments missed without notice or cancelled with less than 24-hour notice. We understand urgent situations do arise and only wish for fair cooperation. Appointment cancellations should be communicated directly to your therapist.

Would you be interested in receiving health information periodically from Balanced Physical Therapy, LLC either via email or postal mailings? Yes No