# INSURANCE FILING AND TREATMENT RELEASE

Assignment of insurance, benefits, release of information and authorization to treat; and the responsibility for payment, assignment of benefits authorization and medical release: I, the undersigned, do hereby expressly guarantee payment in full of any and all claims and charges in consideration for medical services rendered to, or to be rendered to me by Brunswick Physical Therapy. I hereby authorize and demand the assignment of my basic medical, major medical, auto medical, third party medical or any other medical benefits that may apply, herein specified and otherwise payable to me, directly to Brunswick Physical Therapy, LLC. I authorize Brunswick Physical Therapy to release medical information acquired in the course of my treatment and examination to my insurance company. If for any reason the account should become delinquent, I agree to pay all rebilling charges, interest charges, collection of costs and reasonable legal fees. I understand and agree to the Brunswick Physical Therapy payment policies.

Signature: _____ Date: _____

**********

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You may refuse to sign this acknowledgment****

**I understand a copy of this office's Notice of Privacy Practices is available to me upon request.**

**Extended Authorization Option:**
Please list any person you would like to authorize to have access to your billing, make/change or access to your appointment or health information (with the exclusion of information that is protected under State or Federal law) such as **your spouse, caretaker, parent or other family member**. If their name is not listed below no information will be given or changed, including appointments. If you wish not to list anyone, write "N/A".

Name Relationship

_____

_____

**Signature** **Date**

**For Office Use Only**

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)

Brunswick Physical Therapy
70 Souder Road
Brunswick, MD 21716

****Please print in black ink****

## Patient Information

Last Name: _____ First Name: _____ MI: _____

Nickname: _____

**Physical** Address: _____

City/State: _____ Zip: _____

**Mailing** Address: ☐ SAME AS ABOVE

Address: _____

City/State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Can we leave appointment information on your voicemail? Yes _____ No _____

DOB: _____ Age: _____ SSN: _____-_____-_____ Gender: Male Female

Marital Status: Married Single Are you a student: Yes No

Email: _____

Would you like to receive appointment reminders via email? Yes _____ No _____

Employer Name: _____

Responsible Party (minors only):_____

Emergency Contact Name: _____

Relation to you: _____ Phone: _____

Area to be treated: _____ Left Right Surgery/Injury Date: _____

Is this injury from an auto accident _____ Is this a work related injury _____

If so, date of accident _____ State accident happened _____

Attorney Name & Phone (if applicable): _____

Primary Care Physician: _____

Referring Dr.: _____

How did you hear about us: _____

# Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

**Patient Name** _____ **Date** _____

**1. Describe your symptoms** _____

_____

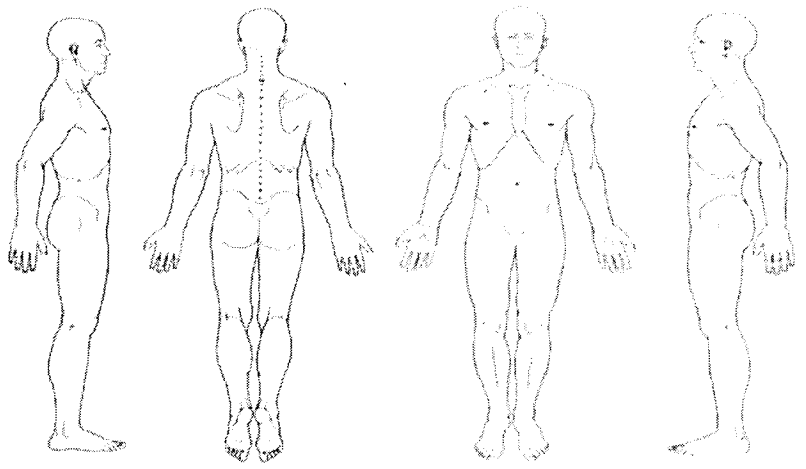
*a. When did your symptoms start?* _____

*b. How did your symptoms begin?* _____

**2. How often do you experience your symptoms?**

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

**Indicate where you have pain or other symptoms**



**3. What describes the nature of your symptoms?**

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

**4. How are your symptoms changing?**

① Getting Better
② Not Changing
③ Getting Worse

**5. During the past 4 weeks:**

*a. Indicate the average intensity of your symptoms*

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

*b. How much has pain interfered with your normal work (including both work outside the home, and housework)*

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

**6. During the past 4 weeks how much of the time has your condition interfered with your social activities?**
*(like visiting with friends, relatives, etc)*

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

**7. In general would you say your overall health right now is...**

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

**8. Who have you seen for your symptoms?**

① No One
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

*a. What treatment did you receive and when?* _____

*b. What tests have you had for your symptoms and when were they performed?*

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

**9. Have you had similar symptoms in the past?** ① Yes ② No

*a. If you have received treatment in the past for the same or similar symptoms, who did you see?*

① This Office
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

**10. What is your occupation?**

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

_____

*a. If you are not retired, a homemaker, or a student, what is your current work status?*

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

**Patient Signature** _____ **Date** _____

**11. Have you completed an advance directive/ Do not Resuscitate Order (DNR)?** A DNR is a request not to have cardiopulmonary resuscitation (CPR) if your heart stops or if you stop breathing. ☐ Yes ☐ No

**12. Did anyone other then your doctor recommend our clinic ?**

_____

**13. Have you had any major life changes during past year?** ☐ Yes ☐ No
(e.g., new baby, job change, death of a family member)

**14. SOCIAL/HEALTH HABITS**

**a. Smoking:** Do you currently smoke tobacco? ☐ Yes ☐No

**b. Alcohol:** How many drinks do you have on an average day? _____

**c. Exercise:** Do you exercise beyond normal daily activities and chores?

(a) ☐ Yes: Describe the exercise: _____
How often do you exercise or do physical activity? _____

(b) ☐ No

**15. FAMILY HISTORY** (circle appropriate response)

| | | | | | |
|---|---|---|---|---|---|
| a. Heart disease: | yes/ no | e. Cancer: | yes/ no | b. Hypertension: | yes/ no |
| f. Psychological: | yes/ no | c. Stroke: | yes/ no | g. Arthritis: | yes/ no |
| d. Diabetes: | yes/ no | h. Osteoporosis/ Osteopenia: | yes/no | | |

**16. MEDICAL/SURGICAL HISTORY**

a. **Please check if you have / ever had:**

| | | | |
|---|---|---|---|
| ☐ Arthritis | ☐ Multiple sclerosis | ☐ Broken bones/fractures | ☐ Muscular dystrophy |
| ☐ Pacemaker | ☐ Parkinson's disease | ☐ Osteoporosis/Osteopenia | ☐ Seizures/epilepsy |
| ☐ Blood disorders | ☐ Allergies | ☐ Circulation/vascular | ☐ Heart problems |
| ☐ Thyroid problems | ☐ High blood pressure | ☐ Cancer | ☐ Skin diseases |
| ☐ Lung problems | ☐ Stroke | ☐ Kidney problems | ☐ Head Injury |
| ☐ Repeated infections | ☐ Ulcers/stomach | ☐ Low blood sugar/ hypoglycemia | |
| ☐ Depression | ☐ Prostate Disease | ☐ Infectious disease. (e.g., tuberculosis, hepatitis) | |
| ☐ Developmental or Growth Problems | | ☐ High blood sugar problems /Diabetes | |

☐ Other: _____ _____

b. **Have you had any of these symptoms within the last 6 months? (Check all that apply)**

| | |
|---|---|
| ☐ Chest Pains | ☐ Changes with Bowels or Urinary Problems |
| ☐ Dizziness or blackouts | ☐ Unexplained weight loss / gain |
| ☐ Unexplained weakness in arms or legs | ☐ Fever / chills / sweats |
| ☐ Calf pain or swelling | ☐ Pain at night |

☐ Loss or changes in sensation

☐ Radicular pain (Numbness, tingling, shooting pain in (L) arm, (R) arm, (L) leg or (R) leg)

☐ Other: _____

c. **Have you ever had surgery?** ☐Yes ☐ No If yes, please describe and include dates:

| | Month / Year | | Month / Year |
|---|---|---|---|
| _____ | / | _____ | / |
| _____ | / | _____ | / |

**For women only:** Vaginal or C-section delivery? ☐ Yes ☐ No

Are you pregnant, or think you might be pregnant? ☐ Yes ☐ No

Do you have other gynecological or obstetrical difficulties? ☐ Yes ☐ No

**17. MEDICATIONS** Do you take any medications? ☐ Yes ☐ No

If yes, please list: _____

**18.** What are your functional goals for physical therapy (be able to do that you are not doing now)? _____

_____

_____