360 PHYSICAL THERAPY & WELLNESS
PREVENT. PRESERVE. PROGRESS.

360 Physical Therapy & Wellness
11830 West Market Place Suite D
Fulton, MD 20759
Phone: 301.957.2564
Fax: 301.957.2565

INTAKE FORM

Name______________________________________Date___________________________

Address___________________________City________________State______Zip_____________

Social Security Number____________________Occupation(s)______________________________

Work Status_____________________

Phone (Home)_________________ Phone (Cell)_________________

Email Address____

DOB_________________________Age_______Gender____________Marital Status____________

How did you hear about us?____

Parent/Guardian/Significant Other

Name______________________________________Relationship________________________

Address___________________________City________________State______Zip_____________

Occupation(s)___________________ Phone (Home)_________________Phone (Cell)____________

Emergency Contact Information

Name______________________________________Relationship________________________

Address___________________________City________________State______Zip_____________

Occupation(s)___________________ Phone (Home)_________________Phone (Cell)____________

Insurance Information

Name of Insured____

Insurance Carrier__________________________________Insurance Plan_____________________

Policy Number_____________________________Group Number____________________________

Contact Number___________________________

Fax Number_______________________________

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Physician Information

Name of Primary Care Physician____

Address________________________________City________________State______Zip_____________

Phone__________________________________Fax____

I hereby authorize the insurance carrier listed above to make payments directly to the healthcare provider *360 Physical Therapy & Wellness* and understand that I am financially responsible for all charges incurred that are not fully covered by my insurance. It is my responsibility to notify *360 Physical Therapy & Wellness* of any changes to my insurance plan otherwise I will be responsible for payment.

Name(Print)____________________________________Date____

Signature (Patient or
Caregiver)____

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TESTIMONIAL RELEASE FORM

Our patients' success is the biggest indicator of our success. At *360 Physical Therapy & Wellness* we use images and video to teach our patients and to educate ourselves. We would love to share your success story with others who experience challenges and limitations to motivate and teach them about our methods. We utilize a combination of images and video that highlight challenges, treatments, and outcomes. That being said, please let us know if we can have your permission to record and use part or all of our treatment sessions and/or possibly writing a testimonial for our clinic.

360 Physical Therapy & Wellness may use photographs, audio and video recordings for the following purposes:

- Educational Materials including Live & On-line Training
- Patient Education & Counseling
- Conference Presentations
- Marketing Materials
- Sales & Profits Endeavors

I hereby grant 360 Physical Therapy & Wellness the irrevocable right and permission to utilize photo and video recordings of me on their business and other websites, promotional flyers, educational materials, derivative works, or any other similar purposes without any compensation. I agree that any and all aforementioned materials and products may be utilized on their website and that I may be identified by name (or title). I acknowledge that all products including but not limited to photographs, videos, edited and unedited images or portraits, audio and video recordings will remain the property of 360 Physical Therapy & Wellness. I waive the right to approve any final product.

I have been informed that I can revoke this consent with written request and that any further active use of said photographs, audio and video recordings will be discontinued thereafter. However, I understand that 360 Physical Therapy & Wellness cannot control how any or all of these materials may be distributed or used by others.

I understand that the aforementioned items cannot be restricted from use/disclosure, payment or operations.

By signing this form, I acknowledge complete and thorough understanding of all terms within this release and that I am bound hereby. I hereby release and acquit forever 360 Physical Therapy & Wellness, all of its current and former employees, trustees, agents, and officers from any and all claims, rights, damages, demands, liabilities, and charges that may arise in direct or indirect connection with the use and or distribution of said photographs, audio and video recordings, including but not limited to any claims of invasion of privacy, appropriation of likeness or defamation.

Name (Print) ____

Signature ____ Date___________________________________

If this release is obtained from a minor under the age of eighteen years, signature of a parent or guardian is also required.

Name (Parent) ____

Signature ____ Date___________________________________

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AUTHORIZATION FOR RELEASE OF INFORMATION

Authorization is not required for the Use or Disclosure of Information
Related to Treatment, Payment, Healthcare Operations or if Required by Law or Rules
HIPAA 143a-Authorization for Release of PHI 10-28-08

I. Patient Name____
(Last) (First) (Middle)

II. Date of Birth_________________________Social Security Number_________________________________

III. Permanent Address____

City_________________________________State_______________Zip______________________________

IV. I, the undersigned, hereby authorize release information of the following information (Please Check One):

_______All Physical Therapy Records _______Treatment Of (Specify Condition):__________________

_______Treatment Received on the Following Dates: from:___________________to:___________________

Other (Please Describe):____

V. Release:

I hereby authorize the release of any necessary and pertinent information including evaluations, assessments, progress notes, daily notes to my insurance company of their representative for the payment of my insurance claim for physical therapy services rendered by 360 Physical Therapy & Wellness.

VI. Assignment of Benefits Statement (See Form Attached):

I authorize my insurance carrier to pay the claim for physical therapy services directly to provider, namely **360 Physical Therapy & Wellness, 11830 W. Market Place Suite D, Fulton, MD, 20759**.

VII. Agreement of Payment & Copayment:

I understand that 360 Physical Therapy & Wellness will attempt to obtain as much reimbursement for care provided through my insurance provider as possible. If for any reason 360 Physical Therapy & Wellness is unable to receive reimbursement from my insurance company, I acknowledge my responsibility for any portion of the bill for physical therapy services that was not covered.

I, _______________________________, understand that most insurances have co-payments or co-insurances which are collected at time of service per each visit. I acknowledge my responsibility for understanding my specific insurance plan and the exact percentage of the bill that I am liable for. I understand that co-payments and co-insurances are collected at each visit and that it is illegal for 360 Phyical Therapy & Wellness to waive them. Failure to pay at the time of visit can result in credit reporting, account being sent to collections, and further legal action. It is my responsibility to notify 360 Physical Therapy & Wellness of any changes to my insurance policy in order to ensure billing accuracy.

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ASSIGNMENT OF BENEFITS

Patient Name:____

Insurance Policy #:____

Insured Name:______________________________ Date of Birth______________

Your relationship to the Insured: ❑ Parent ❑ Spouse ❑ Other:______________

Claim #____

I hereby instruct and direct ___________________ insurance company to pay by check made out and mailed to:

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If my/this current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and **mail it to the above address** for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

(Check each box and sign at the bottom)

- ❑ A photocopy of this Assignment shall be considered as effective and valid as the original.
- ❑ I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- ❑ I authorize the use of this signature on all insurance submissions.
- ❑ I authorize 360 Physical Therapy & Wellness to deposit checks made in my name.
- ❑ I authorize 360 Physical Therapy & Wellness to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- ❑ I understand that I am financially responsible for all charges whether or not paid by insurance.

Dated this ______ day of ______________, 20_____.

___________________________________ ______________________________

Signature of Policyholder Witness

____

Signature of Claimant, if other than Policyholder

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PRE-EXAMINATION FORM

Name____Date____________________________

Age__________ Height_________Weight___________Sex (Male / Female)

Occupation____________________________________Working (YES / NO)

Are you currently experiencing pain? (YES / NO) Location(s)__________________________

How long have you had pain? _____________ Have you experienced this before? (YES / NO)

On a scale of "0" to "10" where 0 = no pain and 10 = worst pain imaginable, please circle **ONE** NUMBER

0 1 2 3 4 6 7 8 9 10

Please list your current active medications and dosage:

____

____

Medical History (**Please Circle All That Apply**):

Abnormal Bleeding	Anemia	Artificial Heart Valve	Cancer
Diabetes	Emphysema	Fainting	Glaucoma
Heart Murmur	High Blood Pressure		Hepatitis (A B C)
Liver Disease	Pacemaker	Shingles	Stroke / TIA
Ulcers	Asthma	Difficulty Breathing	Arthritis
Heart Defect	Heart Failure	Epilepsy	Headaches
Heart Attack	HIV/AIDS	Coronary Artery Disease	Joint Replacement
Renal Disease	Rheumatoid Arthritis		Sinus Problems
Sexually Transmitted Diseases		Thyroid Disease	Sickle Cell Anemia

Other:____

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Please list any surgeries and their respective dates:

____

Terms of Service:

I, the undersigned, certify that I have insurance coverage, and assign directly to 360 Physical Therapy & Wellness all insurance benefits, if any otherwise payable to me for services rendered. I consent to the diagnostic procedures and treatment by the physical therapist necessary to treat my condition(s). I acknowledge that the information provided is accurate and to the best of my knowledge and that this information will be held under the strictest confidence under HIPAA regulations.

Name (Patient)____

Name (Parent / Guardian, if applicable) ____

Signature____ Date______________________