BRILL PHYSICAL THERAPY

Brillpt.com (212) 333-7224

Patient History ***(Please use BLUE or BLACK ink ONLY)***

Patient Name ______________________________ **Gender:** MALE FEMALE
Address: ____________________ **City:** ____________ **State:** ______ **Zip:** ____________
Date of Birth ____________ **Email:** ______________________________
Work Tel# ____________ **Cellular #** ____________ **Home #** ____________
Marital Status *Married* *Single* *Widowed* *Divorced* *Domestic Partner*
Business Address ______________________________
Emergency Contact / Relationship ______________________ **Tel #** ____________
How did you find out about us? ____________ **# of P.T. sessions used this year** ____________
Are you vaccinated? YES/NO **Vaccination Date**________ **Type**________ **COVID Symptoms?** YES/NO

Medical History

Referring Physician ____________ **Specialty** ____________ **Tel#** ____________
Address ______________________________
Off work because of current episode? YES / NO **Since** ____________
Describe relevant symptoms ______________________________
Commenced as a result of ______________________________
Present since ____________ improving unchanging worsening
What makes it better? ______________________________
What makes it worse? ______________________________
Previous Treatments ______________________________
Height ________ **Weight** ________ **Unexplained weight loss** YES / NO
X-Rays: YES / NO **MRI:** YES / NO **Results**____________________
Recent or major surgery YES / NO **If yes, details & date** ____________________
Accidents YES / NO **If yes, details & date** ____________________

Circle any of the following symptoms that you have experienced in the past month:

Loss of appetite	Headaches	Shortness of Breath	Fever	Nausea/Vomiting	Change in bowel
Swelling	Sweats	Bruising/Bleeding	Weakness	Weight Loss	Loss of smell/taste
Numbness	Anxiety	Dizziness	Vertigo	Lightheadedness	COVID

Circle any of the following that you have:

Pacemaker Diabetes Cancer or history of Malignancy Osteoporosis

Patient Agreement **-** Thank you for choosing Brill Physical Therapy. In order to facilitate your treatment, we ask that you read and sign this agreement and authorize:

-A scheduled appointment must be cancelled **24 Business hours in advance** (Monday through Friday)or you are personally liable for a **fee of $175**;
- You agree to inform Brill Physical Therapy of any changes to your contact information or to your health insurance
-Fees are paid to Brill Physical Therapy for co-payment, Co-insurance, deductible, cancellation fees and treatment
- Fees that are not covered by pre-approved medical insurance plans are to be paid at the time of service;
-Brill Physical Therapy will bill your insurance carrier as a convenience to you, however, if your carrier reimburses you, you agree to inform us of the receipt and pay us promptly;
-If any of your services are not covered by insurance, you agree to be responsible for payment of all fees in full.

Consent for Medical Treatment -I hereby authorize Brill Physical Therapy to provide such medical care and administer procedures and treatments as in the judgment of the physical therapists in attendance as deemed necessary and advisable.

Signature of patient ______________________________ **Date** ____________

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Authorization for Release of Information for Insurance Benefits: I hereby authorize and direct Brill Physical Therapy, having treated me, to release to government agencies, insurance carriers, or others, who are financially liable for my care, all information needed to substantiate payment for my care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment **Initials ____**

ASSIGNMENT OF BENEFITS: I hereby assign, transfer and set over to Brill Physical Therapy and the Therapist responsible for my treatment sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers or others who are financially liable for medical care to cover the costs of the care and treatment rendered to myself or my dependent in said facility. I understand that I am financially responsible for the charges not covered by my insurance. A Photostatted copy of this authorization shall be considered as effective and valid as the original. When signed by a Medicare recipient this is a lifetime care authorization. This authorization may be revoked by either me or the above named carrier at any time in writing. **Initials ____**

Non-Payment on Account: Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's Responsible Party understands that Brill Physical Therapy has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient or the patient's Responsible Party understands that they are responsible for all costs of collections including, but not limited to, interest due at 18% APR, all court costs and Attorney fees, and a collection fee will be added to the outstanding balance. **Initials ____**

MEDICAL INSURANCE: We have contracts with a number of insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason. **Initials ____**

Returned check policy: If a payment is made on an account by check and the check is returned for any reason from our bank, the patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a $25.00 Service Charge. Once notice is received of the returned check, Brill Physical Therapy will notify the responsible party. If a response is not made within 15 days from the letter date by the patient or Responsible Party, the account may be turned over to our collection agency and a collection fee will be added to the outstanding balance – in addition to the $25.00 Check Service Charge. **Initials ____**

PRIVACY CONSENT: Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses and demographic data) may be used in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation and licensure). **Initials ____**

Notice of Advice:

I have been informed of the possibility that physical therapy treatment may not be covered by my health care insurer. In that case, I am (the patient) responsible for paying in full for my Physical Therapy services.

Treatment will begin on: ___________
Date

_________________ _______________________________ __________
Insurance Company Signature of Patient Date

Therapist Name: Margaret W. Brill, P.T. License # 011952-1

Therapist Signature: _________________________ Date: ______________