

BROSTROM PHYSICAL THERAPY SPINE AND EXTREMITY INSTITUTE OF SOUTH LYON, LLC

PATIENT INFORMATION

First Name:	MI:	Last Name:	
*Phone: (home)	(cell)	(wc	rk)
*From time to time, it may be necessary for t	he Brostrom PT	staff to leave a detailed	l message on your pho
pertaining to appointment times, health insu			
numbers where you authorize the Brostrom F			•
• Appointment times		I Phone 🗆 W	
• Health insurance coverage			
□ I prefer that the Brostrom PT staff does not			
Address:		5 , ,	
City:			
E-Mail Address:			
Sex: M F Date of Birth:	Mai	ital Status: m s	d w
Student Status:	🗆 Part-tim	e 🛛 Not a Student	
Employment Status:	🗆 Part-tim	e 🗆 Unemployed	\Box Retired
Primary Care Physician (PCP):			
Are you being treated for an injury or ill	ness in which	a party other than vo	our health insurance
<u>company</u> has been found responsible? (
**If yes, please indicate: Auto Wo			
**If yes, please indicate date of onset (i			
Emergency Contact with Phone Numbe			
Phone #:	Relationshi): Treatment i	nformation
Appointment times Health insu			
Optional: <u>Additional</u> person (besides emergency insurance coverage, and/or treatment informati			
Name:	Relationshi	p:	
Appointment times Health insu	rance coverage	🗆 Treatment i	nformation
How did you hear about Brostrom Physi	cal Therapy?		
	.,		
To be completed if you have <u>Medicare</u> a	s active insura	ince:	
1) Are you receiving any form of in-home of			PT)? Yes No
2) Do you have Group Health Coverage th		3	
employer? (Note: if you have a retireme	•	your current or former	Yes No
employer, answer no and skip to questic	-		Vee Ne
2a) If yes, are there 20 or more employees v3) Do you have a Workers-Compensation S			age? Yes No
A WCMSA is a financial agreement that			
	allocates a porti	on of a workers compens	ation Yes No
settlement to pay for future medical ser	•	on of a workers compens	ation Yes No

By signing, I authorize that the above information is accurate and complete to the best of my knowledge. I also understand this form will act as an authorization of release of information to the people and phones specified above. BROSTROM PHYSICAL THERAPY SPINE AND EXTREMITY INSTITUTE OF SOUTH LYON, LLC

HEALTH QUESTIONNAIRE

Nume.							Date:				1		-
Diagnosis:													
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When did th	lis conditi	on beg	in?		day	's ago							
Are you taki	ina prescr	iption I	medicin	e for t	his cond	lition? 🗆	Yes ⊓N	0					
	f yes, plea												
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BROSTROM PHYSICAL THERAPY

SPINE AND EXTREMITY INSTITUTE OF SOUTH LYON, LLC

	Not at All	Several Davs	More than Half the Days	Nearly Every Day
	NOLALAI	Several Days	More than half the Days	Nearly Lvery Day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Please provide a list of all <u>current</u> medications in the table below. \Box I am not currently taking any medications.

Medication Name (including prescription, over-the-counter, herbal, vitamin, and dietary supplements)	Dosage	Frequency	Route Taken (for example: oral, injection, inhaler, etc.)

Please list all surgeries, recent hospitalizations, and pertinent past medical history related to the condition for which you are seeking treatment:

Surgery(ies):	Date:	Surgery(ies):	Date:
Recent Hospitalization(s):		Date:	
Pertinent Past Medical History:			

By signing, I authorize that the above information is accurate and complete to the best of my knowledge.

____/ /____ Date

Signature



BROSTROM PHYSICAL THERAPY

SPINE AND EXTREMITY INSTITUTE OF SOUTH LYON, LLC

PATIENT POLICIES

If you are completing the forms via the Internet: Please open the "Patient Policies Packet" and read the enclosed information regarding your Bill of Rights, Brostrom Physical Therapy's HIPAA Private Policy Statement, Consent to Treatment, Financial Policy, and Cancellation and No-Show Policy. Once complete, initial in the corresponding boxes below to reflect your acceptance to comply with these Policies. Please note that it is <u>not</u> necessary to print the Patient Policies Packet unless you desire a personal copy.

If you are completing the forms in-office: Please read the attached Patient Policies Packet regarding your Bill of Rights, Brostrom Physical Therapy's HIPAA Private Policy Statement, Consent to Treatment, Financial Policy, and Cancellation and No-Show Policy. Once complete, initial in the corresponding boxes below to reflect your acceptance to comply with these Policies.

Note: A parent or legal guardian must initial each of the boxes below if you are under the age of eighteen (18).

Initial:	COVID-19 Symptom Verification:
in iteration.	I understand and will comply with BPT's request to cancel and/or reschedule my appointment(s) if I
	develop a fever (100.4°F), uncontrolled cough, or atypical new onset of shortness of breath, or at least
	two of the following not explained by a known physical condition: loss of taste or smell, muscle aches,
	sore throat, severe headache, diarrhea, vomiting, or abdominal pain.
Initial:	Client Bill of Rights:
initial.	I have read The Client Bill of Rights and agree to maintain by its standards.
Initial:	HIPAA Private Policy Statement:
	I have been given the opportunity to read the <i>detailed</i> private policy statement. I understand this information
	and agree to comply with the policies set forth in the <i>detailed</i> disclosure policy.
Initial:	Consent to Treatment:
	I give my consent for treatment and assignment of claim at Brostrom Physical Therapy.
Initial:	Financial Policy:
	I authorize that I have read and understand Brostrom Physical Therapy's financial policy. I understand I am
	financially responsible for all charges for services rendered, including the balance remaining after all possible
	insurance payments or benefits.
Initial:	Cancellation and No-Show Policy:
	I have read, understand, and agree to the Brostrom Physical Therapy Cancellation and No-Show Policy. It has
	been explained to me and my questions have been answered to my satisfaction.
	By signing below, I hereby authorize my consent to Brostrom Physical Therapy to send appointment reminders
	electronically via text message to my mobile phone or by e-mail. I understand that this service is offered free of
	charge, but standard messaging rates from my mobile carrier may apply depending on my plan. I can withdraw
	my consent to electronic communications by calling Brostrom Physical Therapy at (248) 446-0155.
	Please initial in the corresponding boxes to indicate your consent to receive electronic appointment reminders:
	Please initial in the corresponding boxes to indicate your consent to receive electronic appointment reminders:
	Text reminders Email reminders Decline electronic reminders

Printed name of Patient/Parent/Legal Guardian:_____

Signature of Patient/Parent/Legal Guardian:_____

Date: / /