

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

PATIENT INFORMATION

	MI:	Last Name:			
*Phone: (home)	(cell)		(work)		
*From time to time, it may be necessary for the B	Brostrom PT	staff to leave a d	letailed m	essage on y	your phone
pertaining to appointment times, health insurance					
numbers where you authorize the Brostrom PT s					ntent:
• Appointment times					
• Health insurance coverage					
• Treatment information					
Address:					
City:	State:	Zip:			
E-Mail Address:					
Sex: M F Date of Birth:	Mar	ital Status: m	S	d w	
Student Status: 🗆 Full-time	🗆 Part-time	e 🗆 Not a Stu	dent		
Employment Status: Full-time	🗆 Part-time	e 🗆 Unemplo	yed	Retired	
Primary Care Physician (PCP):					
Are you being treated for an injury or illnes	s in which a	a party other t	han your	health ins	surance
<u>company</u> has been found responsible? (Ple			-		
**If yes, please indicate:					
**If yes, please indicate date of onset (inju					
Emergency Contact with Phone Number.					
	vanie.				
Phone #·					
Phone #: F	Relationship):			
□ Appointment times □ Health insuran	Relationship ce coverage): □ Treat	ment info	rmation	
Phone #: F Appointment times	Relationship ce coverage ntact) to who	o: □ Treat pm we can discuss	ment info your appo	rmation	
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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.

1

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

HEALTH QUESTIONNAIRE

							Date:		1		1		
Diagnosis:													
*Please refer to	the Co	ompari	ative Po	ain Sco	ale docum	ent to a	answer tl	he follo	owina ai	uesti	on: H	low mu	ch pai
have you had in		-									•••••		e p
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0	-	Z	2	4	5	Ū	/	0	9	-	0		
Height:	feet		inch	es	Weig	iht:	lbs						
- y - <u></u>					- 5								
Have you receiv	/ed tre	atmen	t for th	is con	dition bef	ore? 🗆	Yes		🗆 Nc	0			
a. If ye	s, pleas	se list t	he type	es of do	octors you	have se	en:						
			.										
Have you had a		-											
a. If ye	s, pleas	se list t	he num	iber of	surgeries	you hav	e had:						
When did this c	onditiv	on haa	in?		dave	200							
when did this c	onunci	unbeg	···:		uays	ayu							
Are you taking	prescri	iption r	medicir	ne for t	this condit	tion? 🗆	Yes ⊓N	0					
, .					cations:								
	o/ p.eas												
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BROSTROM PHYSICAL THERAPY

SPINE AND EXTREMITY INSTITUTE OF SOUTH LYON, LLC

	Not at All	Several Days	More than Half the Days	Nearly Every 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.

Signature

Date



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: 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:
	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: Text reminders Email reminders

Printed name of Patient/Parent/Legal Guardian:_____

Signature of Patient/Parent/Legal Guardian:_____

Date: / /