BURS & GARRETT PHYSICAL THERAPY ASSOCIATES
2530 North Charles Street, Suite 102
Baltimore, MD 21218

Account Number:_____

Date:

PLEASE PRINT

PATIENT INFORMATION			
FIRST NAME	MIDDLE INITIAL	LAST NAME	
ADDRESS			
CITY	STATE	ZIP CODE	
PHONE NUMBER Home: Cell:	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX
☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced	Occupation:		
EMPLOYER'S NAME (IF RETIRED, PLEASE GIVE YOUR LAST EMPLOYER'S INFORMATION)		PHONE NUMBER	
EMPLOYER'S ADDRESS			
CITY	STATE	ZIP CODE	

EMERGENCY CONTACT	
NAME:	
Address:	
Phone Number:	Relationship:

PHYSICIAN INFORMATION	
REFERRING PHYSICIAN	PHONE NUMBER
PRIMARY CARE PHYSICIAN	PHONE NUMBER

ACCIDENT INFORMATION		
DATE OF INJURY	INJURY AREA	Cause of injury (check what applies) ☐ Workman's Compensation ☐ Auto Accident ☐ Both ☐ Other

ATTORNEY INFORMATION	
ATTORNEY'S NAME	PHONE NUMBER
ADDRESS	

OFFICE USE ONLY
Therapist:

Burs & Garrett Physical Therapy Associates
2530 North Charles Street, Suite 102
Baltimore, Maryland 21218

PLEASE PROVIDE YOUR INSURANCE CARD AND
DRIVER'S LICENSE FOR US TO COPY.

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Co: _____	Insurance Co: _____
Policy:_____ Co-Pay_____	Policy:_____ Co-Pay_____
Address:_____	Address:_____
City:_____ State:_____ Zip:_____	City:_____ State:_____ Zip:_____
Phone:_____ Group:_____	Phone:_____ Group:_____
Effective Date:_____Exp. Date:_____	Effective Date:_____Exp. Date:_____
Policy Holder:_____	Policy Holder:_____
DOB_____/____/____ Relationship:_____	DOB_____/____/____ Relationship:_____
Policy Holder SS#:_____	Policy Holder SS#:_____
Address (if different from patient):_____ _____	Address (if different from patient):_____ _____
City:_____ State:_____ Zip:_____	City:_____ State:_____ Zip:_____
Employer (if different from above):_____	Employer (if different from above):_____
Employer's Address:_____	Employer's Address:_____

Assignment and Release

I, the undersigned, have insurance coverage with the above stated insurance company and assign directly to Burs & Garrett Physical Therapy Associates all medial/insurance benefits if any, otherwise payable to our practice for services rendered. I understand that I am financially responsible for any and all charges whether or not paid by insurance, settlement or otherwise. I hereby direct any attorney or insurance company to immediately pay any and all medial/insurance benefits payable on my behalf to Burs & Garrett Physical Therapy Associates. I hereby authorize Burs & Garrett Physical Therapy Associates to release all information necessary to secure the payment of benefits. I realize I am financially responsible for non-covered services. I authorize the use of this signature on all my insurance submissions. I hereby give permission to the therapist and staff to administer treatment and perform such procedures as deemed necessary in the diagnosis and/or treatment of my condition. In the event collection efforts are required to obtain payment of the charges incurred by the patient, I agree to pay any cost incurred in the collection of this account, including but not limited to court costs, private processing service fee, interest, and attorney fees.

☐ I consent to care and treatment for the above listed patient, who is a minor, and declare I have guardianship over.

_____

Responsible Party Signature Relationship Date

PATIENT HISTORY

Name Date

Medical History: Please check under Yes or No, if you currently have or have had any of the following:

	Yes	No		Yes	No
Currently/Possibly Pregnant	☐	☐	Etoh (Alcohol) Use	☐	☐
Heart Disease	☐	☐	Lung Disease	☐	☐
Hepatitis (Type)	☐	☐	Thyroid	☐	☐
Pacemaker	☐	☐	Latex Allergy	☐	☐
Surgically Implanted Device	☐	☐	Stroke	☐	☐
If "Yes", what kind and where:			High Blood Pressure	☐	☐
_____			HIV/AIDS	☐	☐
Diabetes	☐	☐	Asthma	☐	☐
Tuberculosis	☐	☐	Kidney Disease	☐	☐
Headaches	☐	☐	Chest Pain	☐	☐
Arthritis	☐	☐	Cancer	☐	☐

Are you taking OVER-THE-COUNTER medications?

Aspirin	☐	☐	Advil/Motrin/Ibuprofen	☐	☐
Tylenol	☐	☐	Vitamins/Mineral Supplements	☐	☐

Other _____

Please list any PRESCRIPTION medication that you are currently taking (including pills, injections, etc.)

_____

_____

_____

Any Allergies? _____

List other medical problems and/or prior surgeries with in the past 5 years: _____

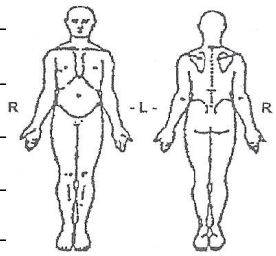
_____

REASONS FOR PHYSICAL THERAPY

What is your main complaint (i.e. pain, radiating pain, numbness, decreased mobility, problems with activities)?

_____

Where is your main complaint located? (Mark on figure) _____



What caused this problem/pain? _____

_____

When did this problem/pain begin? _____

Diagnostic tests (X-rays, MRI, etc.): _____

_____

What are your goals for treatment? _____

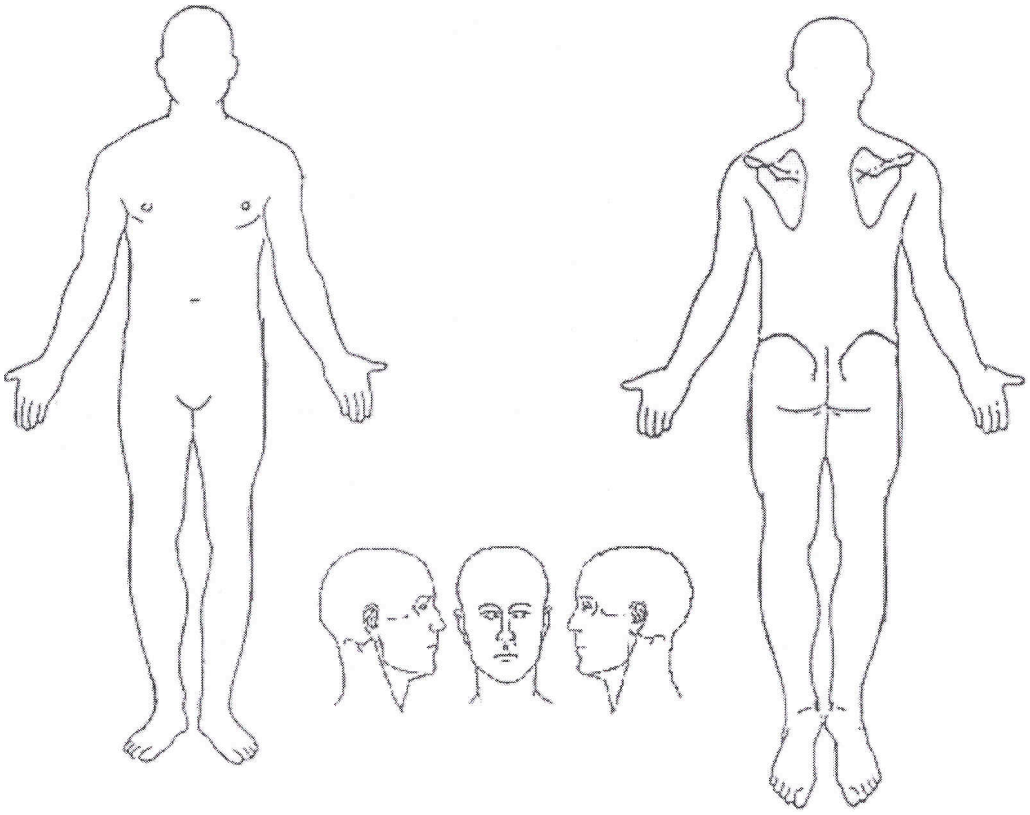
_____ Reviewed by: _____

Patient Signature

Physical Therapist Signature

Where is your pain?

Please mark on the drawings below the areas where you feel your pain.



Please mark an X upon the line in the area which best indicates your current pain level:

NO PAIN

WORST POSSIBLE PAIN

Burs & Garrett Physical Therapy Associates

We strive to provide our patients with excellent service and quality care. Our commitment to your well-being and health care is something that we at *Burs & Garrett Physical Therapy Associates* take very seriously.

Your commitment to your physical therapy program is critical to your success. We will recommend treatment and set goals for you. In order to reach those goals you must do your part and your most important part is to make each and every appointment.

We will give you an appointment card to keep track for your appointments. If you should misplace this, please give us a call to review your appointment dates. We expect you to keep all your appointments; however should you need to cancel please note that we require a 24-hour notice.

If you need to cancel please call our office within 24-hours of your scheduled appointment to reschedule. Our Phone number is 410-889-7872.

If you do not show for your scheduled appointment and have not called to cancel, you may be charged $25 for the missed appointment.

If you miss 3 consecutive appointments we may need to discontinue your treatment.

We thank you for choosing *Burs & Garrett Physical Therapy Associates* and we are looking forward to working with you and helping you reach your goals.

The Staff at Burs & Garrett Physical Therapy Associates

I have read and understand this policy:

_____

Patient/Guardian Date

BURS & GARRETT PHYSICAL THERAPY
2530 N. Charles Street
Suite #102
Baltimore, MD 21218
410-889-7872 (office)
410-889-7992 (fax)

AUTHORIZATION FOR RELEASE OF INFORMATION

I HEREBY AUTHORIZE THE RELEASE OF ALL MEDICAL RECORDS

FOR _____ TO
(Patient's name - please print)

BURS & GARRETT PHYSICAL THERAPY.

_____ _____
(Patient, Parent or Guardian Signature) (Date)

_____ _____
(Social Security Number) (Date of Birth)

Burs & Garrett Physical Therapy, P.A

I have been made aware of how my health care information may be used and have received written disclosure of such as required by the Health Insurances Portability and Accountability Act (HIPAA).

_____ _____

Patient's Signature Date