BREAKTHROUGH PHYSICAL THERAPY, INC PHYSICAL THERAPY
AUTO CLAIM REGISTRATION FORM
(Please complete all questions)

OFFICE USE ONLY

TREATING THERAPIST: _____ **NP RS UPD NBP**

DATE _____ LAST NAME _____ FIRST NAME _____ SEX ◯ M ◯ F

ADDR _____ CITY _____ ST ____ ZIP _____

Please indicate by placing number in parentheses the order in which to call when trying to reach you.

(▼) HOME PH # _____ (▼) WORK PH # _____ (▼) CELL PH # _____

E-MAIL ADDRESS _____ DL/ ID # _____ ST _____ EXP _____

DOB _____ AGE _____ SSN # _____ STUDENT STATUS ◯ FT ◯ PT ◯ NA

EMPLOYMENT STATUS _____ ▼ EMPLOYER _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

MARITAL STATUS _____ ▼ SPOUSE/OTHER NAME _____

SPOUSE'S/PARENT'S EMPLOYER _____ PHONE # _____

RESPONSIBLE PARTY NAME (IF MINOR): _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

DOB _____ AGE _____ SSN # _____

EMERGENCY CONTACT _____ RELATIONSHIP _____ PHONE # _____

WHO MAY WE THANK FOR YOUR REFERRAL OTHER THAN YOUR DOCTOR? _____

REFERRING M.D. NAME _____ PHONE # _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

TREATMENT AREA (body part) _____ Frequency/Duration on Rx _____

DATE OF AUTO ACCIDENT _____ WAS PATIENT DRIVER ◯ PASSENGER ◯ OTHER ◯

NAME OF INSURANCE COVERING ACCIDENT _____ PATIENT'S ◯ OTHER PARTY'S ◯

CLAIM # _____ ADJUSTER _____ PH # _____

CLAIMS OFFICE _____ PH # _____ FX # _____

IF ABOVE IS OTHER PARTY'S INSURANCE, WHAT IS PATIENT'S AUTO INSURANCE? _____

WAS CLAIM FILED? ◯ Y ◯ N POLICY # _____ CLAIM # _____

CLAIMS OFFICE ADDRESS _____ PH # _____

ADJUSTER _____ PH # _____ FX # _____

NOTES (Accident details)

PRIMARY MEDICAL INSURANCE CARRIER NAME _____

CUSTOMER SERVICE PH # _____ PROVIDER SERVICE PH # _____

SUBSCRIBER'S NAME _____ DOB _____ RELATIONSHIP _____

SUBSCRIBER'S CLAIM #/I.D.# _____ GROUP # _____

BREAKTHROUGH PHYSICAL THERAPY, INC
AUTO CLAIM REGISTRATION FORM

MEDICAL PAYMENT AND INFORMATION RELEASE AUTHORIZATION:

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THE CLAIM. **I AUTHORIZE THAT PAYMENT OF MEDICAL BENEFITS SHALL BE PAID DIRECTLY TO BREAKTHROUGH PHYSICAL THERAPY**. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE CARRIER. I HAVE READ ALL THE INFORMATION ON BOTH REGISTRATION FORM PAGES. I CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES IN MY HEALTH STATUS, INSURANCE, OR INFORMATION ON THE REGISTRATION FORMS.

_____ _____
PATIENT SIGNATURE DATE

_____ _____
PARENT/GUARDIAN SIGNATURE (IF PATIENT IS A MINOR) DATE

LIEN:

I, _____, do hereby irrevocably assign to BreakThrough Physical Therapy, Inc. and authorize and direct _____ insurance to pay to BreakThrough Physical Therapy, Inc. from the proceeds of any recovery in my claim or case to the extent of all of the charges for services rendered to include but not limited to: charges for health care services provided, charges for reports and/or records, and charges for supplies. These charges shall be paid whether proceeds of monies are received from med-pay, no fault or any other insurance policy. Furthermore, I do hereby specifically agree to payment of above said proceeds directly to BreakThrough Physical Therapy, Inc. and do hereby authorize and direct any present or future attorney or representative or successor to do the same. I hereby also agree to waive the defense of the statue of limitations as it pertains to any claim filed against me beyond three years (or other statutory period) after services rendered. I understand and agree that this does not relieve me of my personal responsibility to pay for such services and that payment IS NOT contingent upon recovery in my claim/case. If no recovery is made, I will personally be responsible for the balance of my account. I also hereby authorize BreakThrough Physical Therapy, Inc. to furnish the insurance carrier listed above with copies of medical reports (if requested) in reference to services provided by BreakThrough Physical Therapy, Inc.. A photocopy of this agreement shall be binding as the original.

_____ _____
PATIENT SIGNATURE DATE

_____ _____
PARENT/GUARDIAN SIGNATURE (IF PATIENT IS A MINOR) DATE

BreakThrough PHYSICAL THERAPY

MEDICAL HISTORY

Patient Name _____ Age _____

Type of Injury / Condition _____ Onset / Injury Date _____

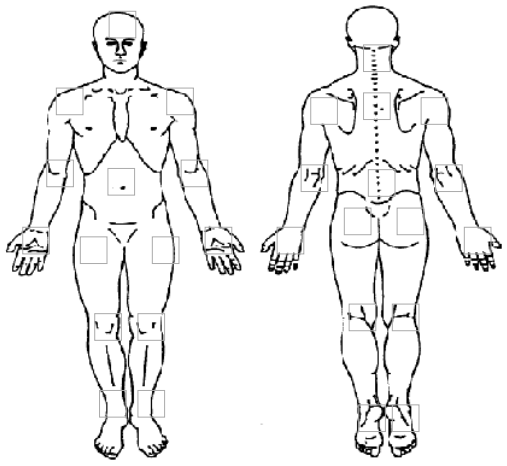
Occupation _____

Sports Activities / Exercise _____

Type of Surgery & Date _____

Next Doctor's Appointment? _____

Describe previous treatment for this condition



Please mark the area(s) of concern

Have you had any of the following tests:

- ☐ X-Ray
- ☐ MRI
- ☐ EMG
- ☐ CT Scan
- ☐ Doppler
- ☐ Ultrasound

What were the findings for the above?

Have you recently noted:

- ☐ Unexpected Weight Loss / Gain
- ☐ Weakness / Stumbling While Walking
- ☐ Changes in Bowel / Bladder Habits
- ☐ Pain at Night
- ☐ Difficulty Swallowing / Speaking
- ☐ Nausea / Vomiting / Dizziness
- ☐ Pain with Coughing / Sneezing
- ☐ Fainting
- ☐ Numbness / Tingling in the Saddle Area
- ☐ Numbness / Tingling in both Hands and Feet at the Same Time
- ☐ Fatigue
- ☐ Numbness / Tingling
- ☐ Change in Vision or Double Vision

Do you have now or have you ever had any of the following?

- ☐ Surgeries
- ☐ Sprains / Strains
- ☐ Heart Problems
- ☐ Circulation Problems / Clots
- ☐ Easy Bruising / Bleeding
- ☐ Pregnancy
- ☐ Loss of Consciousness
- ☐ Diabetes
- ☐ Cancer
- ☐ Asthma / Breathing Problems
- ☐ Indigestion / Heartburn
- ☐ Fractures
- ☐ Blood Pressure Problems
- ☐ Motor Vehicle Accident
- ☐ Osteoporosis / Osteopenia
- ☐ Allergies / Skin Sensitivity

☐ Any previous injury that may affect current care _____

Explain & give approximate dates for any items indicated above

Are you currently taking medications? ◯ Yes ◯ No Name or Type of Medication _____

Type Of Pain: ☐ Sharp ☐ Burning ☐ Aching ☐ Tingling ☐ Numbness ☐ Other _____

Rate your pain (1=minimal 10=severe): At its worst _____ At its best _____

What are your personal or fitness goals?

Is there anything else you would like to include or discuss with your physical therapist?

E-Mail Print Save Reset