COMPLETE BALANCE SOLUTIONS
INSTITUTE *for* REHAB

TM

Date:____________________

Patient Demographics

Patient Name: ____ Soc Sec #:_________________
Last First Mid. Init.

Address: ____
Street City/State/Zip

Home Phone Number: ___________________ Mobile:________________ Email:_______________

Billing Address (if different) ____
Street City/State/Zip

Gender: M F Birthdate:___/____/_____ Marital Status: __S __M __D __W __S

Emergency Contact _______________________________________Phone Number:_____________
Name Relationship

Employment and Other Information

Employer:________________ Occupation:___________________ Work Phone:________________

Employer's Address______________________________City/State/Zip_______________________

Spouse/Parental Information: Name:____________________________ Phone__________________

Address: ___________________________________ City/ST/Zip:___________________________

Referring Provider/Physician Information

Referring Doctor: ____________________________________ Phone______________________

Address: ___________________________ City/ST/Zip_____________________________________

Date of Injury/Onset of Symptoms: ______ **Result of a Fall**? Y N

Is this injury the result of a: Work Related Injury? Y N Is an attorney involved? Y N

Legal Case? Y N Motor Vehicle Accident? Y N If yes, Date of Accident _____________

If YES Above: Case #______________Adjustor Name_______________ Phone______________

Insurance Company Information

Primary Insurance Company:__________________________ Insured's Name:________________

ID # __________________________ Group Name: _____________Group #___________________

Secondary Insurance Company:________________________ Insured's Name:________________

ID # __________________________ Group Name: _____________Group #___________________

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Who may we thank for referring you?____

Medical History

Weight: _________ Height:_____ Do you Smoke? Y N ____ # packs X _______ years

Alcohol Consumption: (circle) Social/Daily/Weekly/Monthly # of drinks ___________

List any Surgical Procedures you have had in the past: ______________________________________

____

Have you been told you have: (CHECK ALL THAT APPLY)

	Yes	NO
Cancer	_____	_____
Heart Disease/Problems:	_____	_____
High Cholesterol	_____	_____
Diabetes	_____	_____
Pacemaker	_____	_____
High Blood Pressure	_____	_____
Seizures	_____	_____
Chronic Headaches	_____	_____
Liver/Kidney Problems	_____	_____
Thyroid Problems	_____	_____
Stroke/CVA	_____	_____
Circulatory Disease	_____	_____
Glaucoma	_____	_____
Osteoporosis	_____	_____
Nervous Disorders	_____	_____
Breathing Problems	_____	_____
Anemia	_____	_____
Stomach/GI Problems	_____	_____
HIV/AIDS	_____	_____

	YES	NO
Bone Disease/Fractures	_____	_____
Bowel/Bladder Problems	_____	_____
Depression	_____	_____
Dizziness	_____	_____
Hernia	_____	_____
Joint Replacement	_____	_____
Back or Neck Problems	_____	_____
Metal Implants:	_____	_____
Unexplained Weight Loss/Gain	_____	_____
Excessive Weakness	_____	_____
Nausea/Vomiting	_____	_____
Fever/Chills/Sweats	_____	_____
Excessive Fatigue	_____	_____
Numbness or Tingling	_____	_____

Difficulty managing bowel/ bladder function: Y N

Arthritis: Y N Where:_________________________

Allergies (please list):_________________________

If you are Dizzy: Please circle the words below that describe your symptoms:

Lightheaded	Unsteadiness	Uncoordinated	Vomiting	Confusion
Vertigo	Spinning	Double Vision	Nausea	Rocking
Imbalance	Giddiness	Headaches	Woozy	Pressure
Blurry Vision	Swimming	Jumpy Vision	Fainting	Disequilibrium

SYMPTOM LEVEL: 0 (Nothing) 1 2 3 4 5 (Severe) 6 7 8 9 10 (Debilitating)

Current: ___/10 At Best:____/10 At Worst:____/10

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Please list any other conditions we may have left out or other pertinent medical diagnoses:

____

____

List any medications you are currently taking:

____

____

Are you currently taking, or have you ever taken Antivert or Meclizine? Yes_____ No___

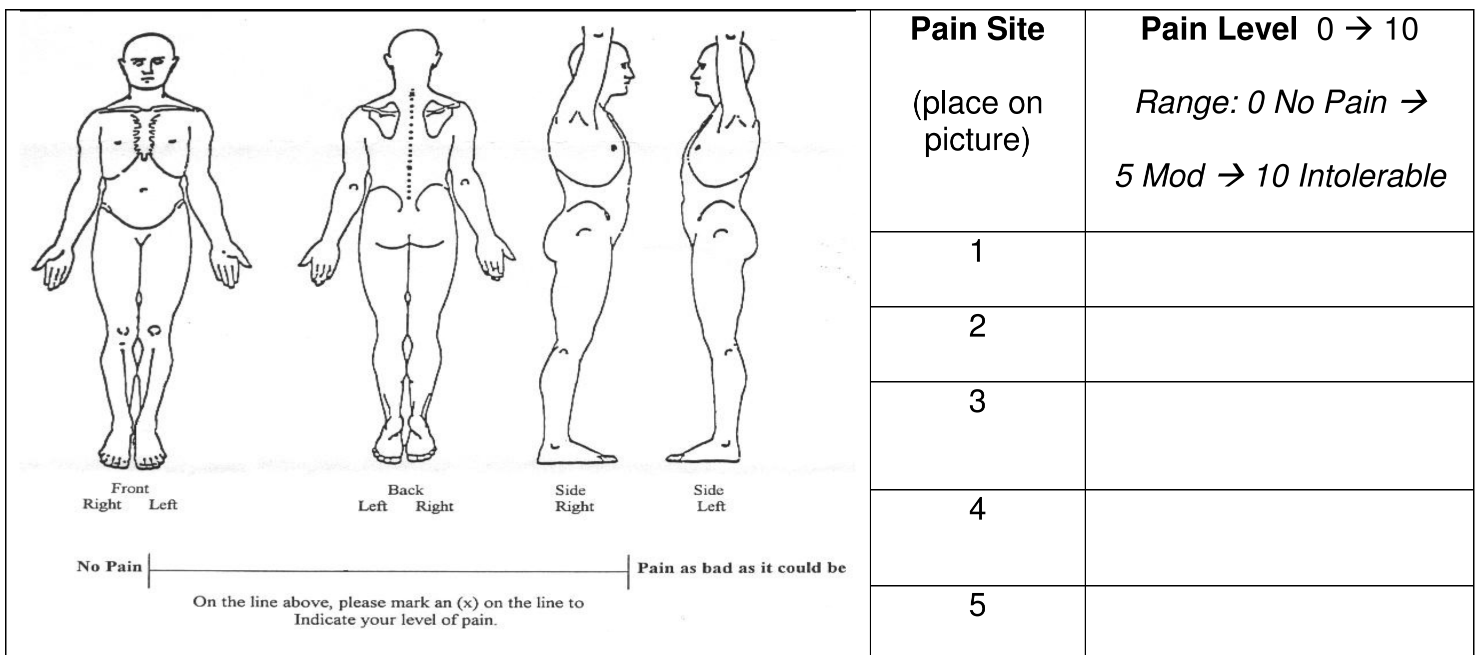
If yes, for what condition?____

Have you had any X-rays, CAT scans, MRIs, or any other diagnostic tests for your recent disorder? If yes, please explain the finding as you understand them?

____

____

____Check this box if you are here due to balance problems or dizziness with no pain and proceed to the next page.



Pain Site (place on picture)	**Pain Level** 0 → 10 *Range: 0 No Pain → 5 Mod → 10 Intolerable*
1	
2	
3	
4	
5	

Complete Balance Solutions. Financial and Practice Policies

PLEASE INITIAL EACH PARAGRAPH

1. I, _______, understand **I am ultimately financially responsible** for the physical therapy that I am about to receive. I understand I am to pay for all co-payments, at the time of service, and payment can be submitted via Check or Cash. I realize that *Complete Balance Solutions Institute for Rehab*, will bill my insurance company for services rendered. I understand I have a choice to bill the insurance company if I choose to, and render payment at time of service to *Complete Balance Solutions Institute for Rehab*. I understand that I am personally responsible for any balances in payment not paid by my insurance provider to *Complete Balance Solutions Institute for Rehab*. I acknowledge that if my balance is forwarded to **collections**, **a 40% fee** will be added to the balance.

2. I, _______, understand that it is **my own responsibility to understand my insurance coverage** regarding services I will receive at to *Complete Balance Solutions Institute for Rehab*. If I have questions regarding benefits, I shall take them up with my insurance agency. I understand *Complete Balance Solutions Institute for Rehab* does **NOT** play any role in how policies are written by my insurance company. I am responsible **if I have a large deductible** and understand I will be billed accordingly, until I have met my deductible. I know it is my responsibility to inform *Complete Balance Solutions Institute for Rehab* if I change my plan or insurance carrier(s).

3. I, _______, understand that **late cancellations and no-show** appointments will be subject to a $50.00 charge. I understand that if I No Show or Cancel 3 times, I will be discharged from Physical Therapy services, unless unforeseen substantial circumstances resulted in the no show or cancellation.

4. I, _______, hereby acknowledge that I have received a copy of *Complete Balance Solutions Institute for Rehab's* Health Information Privacy and Practices Act (HIPPA) forms. I further acknowledge that a copy of the current notice is readily available on the reception desk if I should need additional copies.

Assignment of Benefits / Release of Information / Consent to Treatment

I have read and I agree with the above policies. I hereby authorize/assign my physical therapy insurance benefits to be paid directly to *Complete Balance Solutions Institute for Rehab*. I also authorize *Complete Balance Solutions Institute for Rehab* to release any necessary information to process this claim. I authorize the release of any medical information necessary to process claims. By signing below, I authenticate that authorization for Assignment of Benefits and Consent to Treatment by Providers at *Complete Balance Solutions Institute for Rehab*..

____ Signature

_______________ Date

____ Relation to Patient (if different)

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