**Don Berlyn Physical Therapy**

**Flagstaff Arizona 86001**

**Patient Name**____________________________________**DOB**_____________**Age**______________
**Mailing Address**_____________________________________________ **Apt. #**__________________
**City**_____________________ **State**____ **Zip Code**________ **Home Phone**______________________
**SSN**_________________________
**Marital Status S M D W** **E-mail Address**_________________________________
**Employer**_____________________________ **Occupation**____________________________________
**Address**_____________________________________________________________________________
**City**_____________________ **State**____ **Zip Code**________ **Work Phone**_______________________
**Referred By**_________________________ **Primary Care Physician**____________________________

**Spouse, Parents, or Emergency Contact**

**Name**_________________________________**Relationship**____________**Phone**__________________
**Address**__________________________ **City**_______________ **State & Zip**______________________
**Employer**_________________________________ **Work Phone**________________________________
**Date of Present Injury or Chronic Condition**_______________________________________________

## Insurance

**Private Insurance**________________________________Phone________________________________
Address____________________________City_________________State______ Zip_________________
Name of Policy Holder if other than patient_____________________ _____________________________
ID #________________________ Group #__________________Policy Holder DOB_________________

**Secondary Insurance**______________________________Phone_________________________________
Address____________________________City_________________State_______Zip________________
Name of Policy Holder if other than patient__________________________________________________
ID #________________________Group #___________________Policy Holder DOB________________

**Is this an Industrial (work related) injury? ___ or an Auto accident covered by Auto Insurance? ___**
**Please complete appropriate insurance information.**
**Industrial Carrier**_______________________________________ Contact Person__________________
Address_____________________________City_____________________State______ Zip____________
Phone________________________________ Claim #___________________Date of injury___________
Employer at Time of Injury___________________________________________________________
Address_____________________________ City____________________ State______ Zip____________
Contact Person___________________________________Phone_____________________________

**Auto Insurance Co**.______________________________ Policy #_____________________________
Address____________________________ City__________________ State__________ Zip____________
Contact Person_________________________________________Phone____________________________
Name of Policyholder___________________________________ Claim #_________________________
Date of Accident__________________________________ Do you have an attorney___________________
Attorney Name_________________________________________Phone____________________________

___________________________________________________________ ______________________

**Patient/Responsible Party Signature** **Date**

# PATIENT HEALTH HISTORY

**Name________________________________________________________ Date______________________**

**Have you had any Physical Therapy or chiropractic care in the past 12 months? ___________**

**Have you ever had or been diagnosed with:**

| | | |
|---|---|---|
| **Allergies** | **Yes________** | **No________** |
| **Arthritis** | **Yes________** | **No________** |
| **Asthma** | **Yes________** | **No________** |
| **Chest Discomfort** | **Yes________** | **No________** |
| **Cancer** | **Yes________** | **No________** |
| **Diabetes** | **Yes________** | **No________** |
| **Headaches** | **Yes________** | **No________** |
| **High Blood Pressure** | **Yes________** | **No________** |
| **Extreme Fatigue or Tiredness** | **Yes________** | **No________** |
| **Heart Murmurs or Unusual Cardiac Findings** | **Yes________** | **No________** |
| **Orthopedic Problems (joint pain)** | **Yes________** | **No________** |
| **Phlebitis, Emboli** | **Yes________** | **No________** |
| **Peripheral Vascular Disease** | **Yes________** | **No________** |
| **Respiratory Disease** | **Yes________** | **No________** |
| **Rheumatic Fever** | **Yes________** | **No________** |
| **Stroke** | **Yes________** | **No________** |
| **Unusual Shortness of Breath** | **Yes________** | **No________** |
| **Unexpected Weight Loss** | **Yes________** | **No________** |
| **Are you currently pregnant?** | **Yes________** | **No________** |

**If you answered yes to any of above questions, please provide details here:_______________________________________________________________________________**
**_________________________________________________________________________________.**
**Are you taking any Medication? _________**
**Please indicate medication(s) and how often taken: ___________________________________**
**_________________________________________________________________________________**

**Have you had any surgery recently? (Last 12 months)________**
**Please indicate type of surgery_______________________________________________________**

# Payment

**Time of Payment: Payment is expected at the time services are rendered. We do provide a service to our patients by billing your insurance BUT it is your responsibility to provide the proper insurance claim information for us to mail directly from our office. Please note the following important items:**

- **You are financially responsible for any balance NOT COVERED by your insurance.**
- **Deductible amounts and co-payments are COLLECTED AT THE TIME OF SERVICE as required by your insurance carrier.**

**Don Berlyn Physical Therapy does our best to promptly and correctly bill your insurance company, but it is essential that you notify us immediately when you have a change in insurance information or a change of address.**

**We accept cash, check, Visa, and MasterCard. All bills are considered past due after 60 days and payment is required at such time. Past due accounts will be assessed a 1.5 % interest charge per month. Please contact our office if payment arrangements need to be discussed. Should it become necessary to start collection proceedings for any unpaid account balance, you will be responsible for these collection charges and they will be added to your account. It is agreed that if payment is delayed because Don Berlyn Physical Therapy has agreed to accept a lien, a recovery charge will be assigned.**

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**PATIENT/RESPONSIBLE PARTY SIGNATURE DATE**

## APPOINTMENT SCHEDULING – CANCELLATION POLICY – NO SHOW FEE

**We ask that you please be prompt when arriving for your scheduled appointment. We do our very best to adhere to your appointment time because we believe your time is valuable. Patients who arrive late for their appointment may be asked to reschedule. If you must cancel an appointment, PLEASE TRY TO CALL 24 HOURS IN ADVANCE OR YOU WILL BE SUBJECT TO A CHARGE OF $35.00. Although we realize that emergencies do arise, notification in advance will allow us to plan our day more efficiently for the betterment of all our patients.**

## PLEASE READ THE FOLLOWING STATEMENTS AND SIGN BELOW

### CONSENT OF TREATMENT AND AUTHORIZATION TO RELEASE AND OBTAIN INFORMATION

**I hereby consent to examination and treatment by Don Berlyn Physical Therapy and authorize Don Berlyn Physical Therapy to release or obtain any medical or incidental information that may be necessary for physical therapy or in processing insurance claims. I authorize release of all records on request.**

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**PATIENT/RESPONSIBLE PARTY SIGNATURE DATE**