Baker Physical Therapy, LLC

76 Valley Road
Cos Cob, CT 06807
Email: bakerptct@gmail.com
Phone: 203-419-6390

Welcome to Baker Physical Therapy, LLC. Thank you for choosing us on your journey to health and wellness. Please take a moment to fill out our intake form as it will help us make better use of your time during your initial evaluation.

Date:		
Name:		
Address:		
City:	State:	Zip Code:
Primary Phone:	Business/Alternative Phone:	
Email Address:		
Date of Birth:		

Marital Status: ( ) Single ( ) Married ( ) Other Gender you identify as: ( ) M ( ) F

Emergency Contact	
Name:	Relationship:
Contact Number:	

Payment Information	
Please circle: Mastercard Visa AMEX Discover Check Cash	
Name as it appears on card:	
Credit card number:	Expiration date:
Billing address:	Zip code:
Signature:	CVV:

We want to provide excellent care in a stress-free, healing, and respectful environment. Please take a moment to review our financial policies. Should you have any questions or concerns, feel free to contact our administrative team.

Appointment Fee	This authorizes Baker Physical Therapy, LLC to charge credit card on file at time of service rendered, based on fee sheet, or in the event of a late cancellation or no show
Cancellation Fee	60% of the booked appointment time
No Show Fee	100% of the booked appointment time
Non-sufficient Funds Fee	$30.00
Cancellation/Stopped Check fee	$30.00
Late Fee (charged in increments of 15 minutes)	$50.00

- You can avoid the late and cancellation fees listed above. If you need to cancel your appointment, notify our administrative staff 24 hours prior to your appointment time. This can be done via email to bakerptct@gmail.com or by phone or text to 203-419-6390.
- If you cancel late or don't show up more than two times in a row, we will hold you responsible for the appointment slots, and you will have to pay in full prior to your next appointment.
- You will also be responsible for collection fees and court costs in the event of default of payment charge.

I have read and fully understand Baker Physical Therapy, LLC's financial responsibility. I acknowledge full financial responsibility for services rendered by Bake Physical Therapy, LLC and its staff.

Patient's Name:_____

Patient or Guardian Signature: _____

Date:_____

Patient History

Describe the current problem that brought you here?

_____

When did your problem first begin?

_____

Was your first episode of the problem related to a specific incident? Yes / No

Please describe and specify _____

Since that time has the problem: □ stayed the same □ gotten worse □ gotten better

Have you seen another provider (MD, PT, etc) for this current problem? Yes / No

If Yes – Please list provider _____

Describe previous treatment/exercises _____

Did you get relief from the treatment(s) listed above? Yes / No

Rate the severity of this problem from 0 -10, 0 is no pain at all, 10 being the worst pain imaginable Currently

_____ At its Best _____ At its Worst _____

What makes it better?

_____

What makes it worse?

_____

Describe the nature of your pain (i.e. constant, intermittent, burning, sharp, dull, achy)

_____

General Health: □Excellent □Good □Average □Fair □Poor

Activity/Exercise: □None □1-2 days/week □3-4 days/week □5+ days/week

Have you fallen in the past year? Yes / No

If Yes – How many times in the past year? _____ In the past two years? _____

Has a fall resulted in an injury? Yes / No

If Yes – Please describe your injury_____

Height _____ Weight _____

Tobacco Usage / Day _____

Have any of your medications changed recently? Yes / No

Medications and/or supplements – oral, patches, injection, etc. Specify dosage and reason for taking (please indicate if you have attached a separate list of medications by checking box - □)

_____

_____

Have you had any surgeries? Yes / No List type of surgery and date.

_____

_____

Have you ever had any of the following conditions or diagnoses? Circle all that apply:

Cancer	Heart problems	Emphysema/chronic bronchitis
Epilepsy/seizures	Head injury	High blood pressure
Multiple Sclerosis	Stroke	Acid reflux/belching
Ankle swelling	Alcoholism/drug problems	Allergies (list below)
Anemia	Chronic Fatigue Syndrome	Depression/Anxiety
Diabetes	Fibromyalgia	Headaches
Hearing loss/problems	Hypothyroid/Hyperthyroid	Latex sensitivity
Kidney disease	Hepatitis	Raynaud's
Smoking history	Vision/eye problems	Arthritic conditions
Bone fracture	Joint replacement	Low back pain
Osteoporosis	Sports injuries	Stress fracture
TMJ/neck pain	Anorexia/Bulimia	Childhood bladder problems
Irritable Bowel Syndrome	Pelvic pain	Sexually transmitted disease
Physical or sexual abuse	Sacroiliac/Tailbone pain	

Other: Please list

_____

What goals would you like to accomplish with physical therapy at Baker Physical Therapy?

_____

_____

MEDICARE PATIENTS: During this calendar year - have you received ANY physical therapy or speech therapy for any part of the body (neck/back/shoulder, etc.) □ Yes □No IF YOU SELECTED YES, PLEASE CONTACT OUR BILLING DEPARTMENT

Signature: Date:

_____ _____

Parent/Guardian (if under 18 years of age): Date:

_____ _____

Payment and Insurance

Baker Physical Therapy, LLC is an OUT OF NETWORK provider. Payment is due at the completion of each visit and a valid credit card must be kept on file.

It is the patient's responsibility to understand insurance coverage prior to receiving treatment and to inform Baker Physical Therapy, LLC of any changes.

Baker Physical Therapy (BPT), LLC DOES NOT participate with Medicare. BPT is not a Medicare provider and cannot submit to or communicate with Medicare. In addition, Baker Physical Therapy is not permitted to provide superbills to Medicare patients.

Clinic and In-Home Physical Therapy Fees: Initial Evaluation: $275 based on treatment location. Subsequent Physical Therapy Session: $225. In-home or weekend sessions are subject to an additional $50 travel/convenience fee.

I have received a copy of the HIPAA policy and procedures and it has been explained me. Additionally, my signature below authorizes Baker Physical Therapy, LLC to release my medical records and any relevant information to my insurance company for reimbursement directly to me. My signature below also indicates my permission to be evaluated and treated by a licensed physical therapist from Baker Physical Therapy, LLC.

Electronic Communications: I give Baker Physical Therapy, LLC permission to communicate with me via email and/or text message regarding therapy, billing/sales receipts, appointment reminders, scheduling, and information updates at the email address I provided.

INSURANCE CARRIER: _____

Policy/ID Number: _____ Group Number: _____

My signature indicates permission for Baker Physical Therapy, LLC to bill my credit card $275 for the initial evaluation and $225 per physical therapy session. An additional charge of $75 is assessed to in-home or weekend appointments. These fees also apply to no show appointments and late-cancel sessions as outlined in our cancellation policy above. My signature also confirms that I understand and accept Baker Physical Therapy's insurance policy.

Patient Signature:_____(Responsible party for minors under 18 years)

Consent for Physical Therapy

Evaluation and treatment Informed consent for treatment: The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy evaluation and treatment have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the evaluation, treatment, and options available for my condition.

Pelvic floor patients: I understand that to evaluate my condition it may be necessary to have my therapist perform a pelvic floor muscle examination. This examination is performed by observing and/or palpating the perineal region including the vagina and/or rectum. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility, and function of the pelvic floor region. Such evaluation may include sensors for muscle biofeedback.

Potential benefits: I may experience an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility, and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Potential risks: I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary. If it does not subside in two to three days, I agree to contact my therapist.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical, or pharmacological alternatives with my physician or primary care provider.

Cooperation with treatment: I understand that for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

No warranty: I understand that the physical therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my therapist will share with me her opinions regarding potential results of physical therapy treatment for my condition and will discuss all treatment options with me before I consent to treatment.

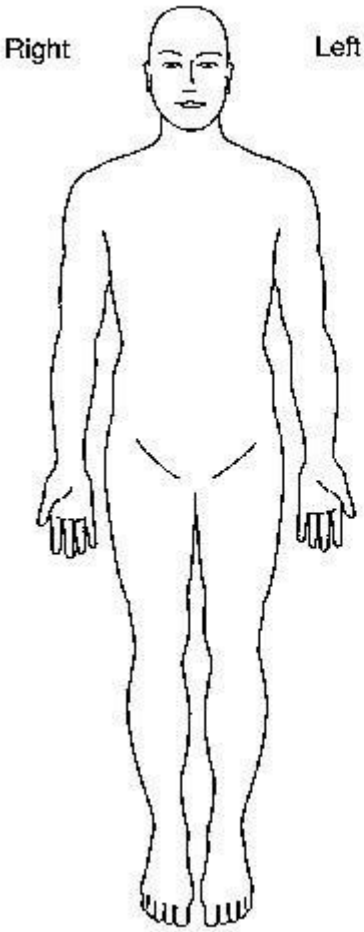
Release of medical records: I authorize the release of my medical records to my insurance company, physicians/primary care provider, or other providers that are managing my care.

Chaperone request: Any adult or minor can request a chaperone at any time. I WILL INFORM MY THERAPIST OF ANY CONDITION THAT WOULD LIMIT MY ABILITY TO HAVE AN EVALUATION OR TO BE TREATED. I HEREBY REQUEST AND CONSENT TO THE EVALUATION AND TREATMENT TO BE PROVIDED BY THE THERAPIST.

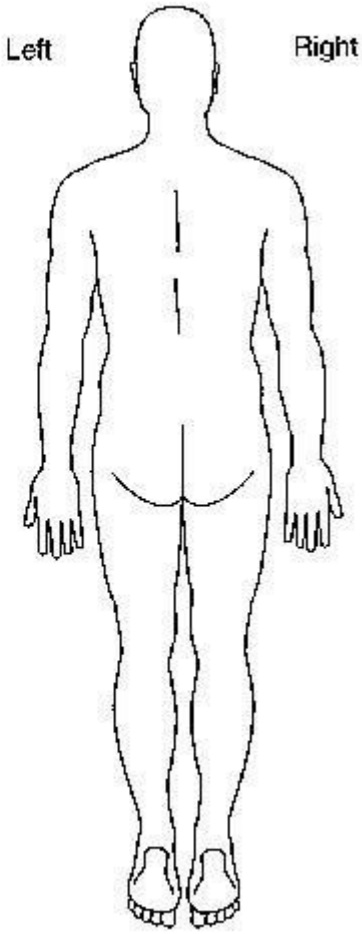
Patient Name: (Please print) Date:
Patient Signature:
Signature of Parent or Guardian (If applicable):
Relation to minor and contact number:

We look forward to assisting you in your healing journey!!

Please color in those areas where you usually feel pain.



Front



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