



TOTAL BODY THERAPY^{LLC}

Holistic Physical & Occupational Therapy

Medical History Form

Name: _____

Date of Birth: _____

| Please Check Yes or No | Yes | No | Please Check Yes or No | Yes | No |
|--|-----|----|---|-----|----|
| Allergies | | | Arthritis | | |
| Sinus Trouble | | | Numbness/Tingling | | |
| Dizziness, Fainting Spells | | | Loss of Coordination | | |
| Change in Vision | | | Limited Joint Movement | | |
| Ringing in Ears, Difficult Hearing | | | Diabetes | | |
| Headaches | | | Hepatitis, Jaundice or Liver Disease | | |
| Problems with Teeth or Gums | | | Problems of the Immune System | | |
| Anxiety/Stress | | | Respiratory problems, emphysema, bronchitis, etc. | | |
| Depression | | | Kidney Trouble | | |
| Memory Loss | | | Tuberculosis | | |
| Problems with Sleep | | | High Blood Pressure | | |
| Chest Pain/Discomfort or Palpitations | | | Low Blood Pressure | | |
| Difficulty Breathing/Asthma | | | Cancer | | |
| Epilepsy/Seizures/Neurological Disease | | | Nighttime urination, uncontrollable urge to urinate | | |
| Thyroid Problems | | | Stroke | | |
| Stomach Ulcer or Hyperacidity | | | Chicken Pox | | |
| Rheumatic Fever | | | Mumps/Measles | | |
| Multiple Sclerosis | | | Alcoholism | | |
| Heart Disease/Pacemaker | | | Arteriosclerosis | | |
| Typhoid Fever | | | Polio | | |
| Appendicitis | | | Pneumonia | | |
| Herpes | | | Pleurisy | | |

| Please Check Yes or No | Yes | No | Please Check Yes or No | Yes | No |
|--|-----|----|---|-----|----|
| Have you ever had a serious fall? | | | Have you ever been knocked unconscious? | | |
| Have you ever experienced any blows to the head? | | | Have you ever been in a car accident? | | |
| Are you pregnant? | | | Do you leak when you cough, jump or sneeze? | | |
| Latex Allergy? | | | Sulfa Allergy? | | |

Please explain any questions you answered 'Yes' to: _____

Hospitalizations & Surgeries: (include dates and reasons): _____

Do you have any diseases, conditions, or problems not listed above that you think we should know about? _____

The above information is thorough and accurate to the best of my knowledge.

Patient Signature (or Guardian)

Date

Office Locations: Manchester, Tilton, Newington, Concord and Plymouth www.TotalBodyTherapy.com

Call us toll free at: 866.621.9800 or email us at: questions@totalbodytherapy.com



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Authorization to Treat and Bill for Services Rendered

| Rates are as follows: | Full Fee | Discount Fee |
|---|----------|--------------|
| Evaluation | \$320.00 | \$120.00 |
| Re-Evaluation | \$160.00 | \$75.00 |
| Comprehensive Treatment (46-60 minutes) | \$320.00 | \$120.00 |
| Regular Treatment (31-45 minutes) | \$240.00 | \$100.00 |
| Intermediate Treatment (16-30 minutes) | \$160.00 | \$75.00 |

Authorization of Treatment:

I hereby authorize the performance of therapeutic services by Total Body Therapy, LLC. Therapy is provided at my request. I fully understand that the expense of this care shall be my responsibility and I agree to pay Total Body Therapy, LLC the full amount for all services rendered. I will notify Total Body Therapy, LLC promptly if I start receiving any home health care benefits paid by Medicare during the course of my therapy with Total Body Therapy, LLC.

Payment Policy – CO-pays are due at the time of service.

Major medical insurances, Medicare, NH Medicaid, Blue Cross/Blue Shield of NH, United Healthcare, Freedom Care, Harvard Pilgrim, and Aetna are accepted. Our office will kindly bill your insurance company for you, but please realize that **the ultimate responsibility of verifying the coverage with your insurer is yours.** You will be responsible for any balance not paid by your insurance carrier.

Is this going to be a Worker’s Compensation or Motor Vehicle Claim? ____ Yes ____ No

You must call the office (603) 622-0909 with your claim number, so that we are able to process that claim.

Have you previously had any Worker’s Comp or Motor Vehicle claim opened that pertained to the reason we are seeing you? _____ Yes _____ No

Changes in Insurance

You must inform Total Body Therapy, LLC of any changes in your insurance. If you do not inform Total Body Therapy, LLC and your insurance denies payment, you will be held responsible for any charges not paid by your insurance carrier. You may contact the administrative office at 603-622-0909 to inform them of any changes.

Returned Checks

There is a \$20.00 service charge on any returned check. Payment in full will be required within 10 days of notice.

I have read and agree to the terms of the above information. I understand that payment is expected at the time services are rendered and that I am responsible for any balance for the service rendered by Total Body Therapy, LLC. If under the age of 18 a parent or legal guardian must sign below:

PATIENT NAME (PLEASE PRINT) _____

PATIENT SIGNATURE _____ DATE _____

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CANCELLATION POLICY/PATIENT GUIDELINES

- In order to receive maximum benefit from your rehabilitation program, it is of utmost importance that you attend your therapy appointments and follow home instruction.
- We request that if you are unable to keep your appointment that you notify the administrative office 24 hours prior to your scheduled appointment.
- If you cancel or “no-show” without sufficient notice, you may be subject to a \$50.00 fee, payable by you, not by your insurance company.
- It is your responsibility to inform staff members in advance of any physician appointments.
- **You are subject to be discharged from our services after three missed appointments (within a four week period).**

Your cooperation is appreciated. We look forward to working with you and obtaining optimum outcomes from your rehabilitation program.

This form has been fully explained to you and you understand it.

PATIENT NAME (PLEASE PRINT) _____

PATIENT SIGNATURE _____ DATE _____

(Signature of Patient or Legal Representative)

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Patient Bill of Rights

My signature below indicates that I have been provided with a copy of the Patient Bill of Rights, that I understand the contents and acknowledge that I am aware of who to call with any complaints.

Patient Name (Please Print)

Signature of Patient or Legal Representative

Date

HIPAA Patient Consent Form

My signature below indicates that I have been provided with a copy of the HIPAA Notice of Privacy Practices.

Patient Name (Please Print)

Signature of Patient or Legal Representative

Date

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