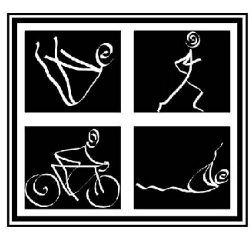

Bodies in Balance Physical Therapy, PLLC

Orthopedic Manual Physical Therapy

Pilates-Based Rehabilitation

Biomechanical Evaluation

17 N. Market Street • Chattanooga, TN 37405 • Tel: 423.255.6105 • Fax: 423.756.4782

WELCOME TO OUR PRACTICE. WE ARE DELIGHTED TO HAVE YOU AS A NEW PATIENT AND LOOK FORWARD TO PROVIDING YOU WITH THE HIGHEST QUALITY CARE.

OUR PHILOSOPHY AND PROMISE TO YOU

We continually strive to incorporate the latest techinques and research into our practice. We believe that both you, the patient, and we as therapists benefit when we seek to provide you with the best care possible.

To ensure accurate and thorough treatment, we begin with a detailed evaluation that looks beyond the injury and into the functional relationships of the body to the injury. Our experienced physical therapists with advanced training then provide individualized specialty care. We also educate our patients and help them learn to care for their dysfunctions, and educate the community regarding the possibilities of manual therapy, Pilates-based rehabilitation, Pilates, and strength and conditioning instruction.

We have intentionally structured our practice in a way that provides our patients with the best learning environment. Each therapist sees one patient per hour, allowing each patient to spend the entire hour working one on one with the therapist.

OUR EXPERTISE

Dr. Miller graduated from the Masters of Physical Therapy program at Emory University and earned his advanced clinical doctorate in Physical Therapy at Andrew’s University. In his hands-on clinical practice, he combines a practical knowledge of the mechanical inter-relationships of the body with the most advanced training in orthopedic manual physical therapy. Dr. Miller has achieved the following, which are the highest qualifications available in the U.S.: a board certified orthopedic specialist, certified orthopedic manipulative therapist, a Fellow of the American Academy of Orthopedic Manual Physical Therapists and a Clinical Fellowship Instructor.

A graduate of the Physical Therapy program at UPS with honors, Lisa Fox’s clinical expertise combines orthopedic manual physical therapy and the application of Pilates principles and medical exercise therapy in rehabilitation. Extensively trained in medical and functional exercise approaches and orthopedic manual physical therapy through three different schools of advanced studies, Lisa offers a comprehensive approach not only to orthopedic manual physical therapy but also to Pilates based personal training. Currently Lisa is on extended leave from active practice.

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Appointment Reminders

Name: ________________________________ Minor Name:____________________________________

You are scheduled for an appointment on____ with:

Bryant Miller, PT, DSc, OCS, COMT, FAAOMPT

This packet contains:

- Billing and Payment Policy - *Please read and sign*
- Cancellation Fee Policy - *Please read and sign*
- Registration Form and Subjective Evaluation - *Please fill out completely*
- Scheduled Appointments and Courtesy Call Policy

Bring the following to your initial appointment:

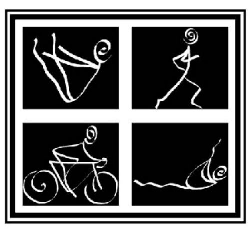
- ☐ Completed New Patient Packet
- ☐ A written prescription for physical therapy from your PCP or referring doctor
- ☐ Insurance card or worker's compensation card (unless you plan to pay fee-for-service)
- ☐ A pair of loose fitting shorts with an elastic band
  - **Women:**
    - ☐ Scoop back sport/jog bra (no T-back sport/jog bras)
    - ☐ Tank top
    - ☐ T Shirt
- ☐ A pair of tennis shoes and a pair of shoes in which you are regularly active and any inserts
- ☐ Appointment calendar to schedule future appointments

Payment options:

We accept check or cash. We do have a payment plan option available. Please discuss any financing concerns you might have with the therapist at your initial evaluation.

Initial Appointment Times:

Plan to spend approximately 75 minutes with your therapist during the initial evaluation.
Successive treatments are one hour long.



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Directions to Bodies in Balance Physical Therapy, PLLC

From Interstates 24 or 75, take downtown Chattanooga exit (Hwy 27 North). We are located in North Chattanooga.

NOTE: If you are unfamiliar with the area, taking the Manufacturer's Rd. exit from Hwy 27 North will provide you with the most direct route to our office. Directions from the Manufacturer's Rd. exit are as follows:

DIRECTIONS FROM ROUTE 27

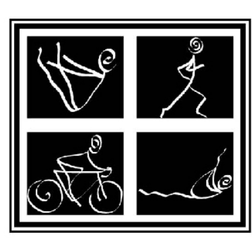
Exit at Manufacturers Rd. At bottom of exit turn east onto Manufacturer's Road (toward Frazier Ave./Cherokee Blvd). Go to end of Manufacturer's Road. Turn right onto Cherokee Blvd. At first traffic light, turn left onto N. Market. Within less than one half block, turn left into shopping center between First TN Bank and Longhorn Resturant. The studio is to your left.

FROM DOWNTOWN

Take Market Street toward river. Cross river on Market Street Bridge. Go through one traffic light. Within less than one half block, turn left into the shopping center between the First TN Bank and the Longhorn Resturant. The studio is to your left.

PARKING

Allowed in stamped RESERVED slots on right, unmarked slots and after hours parking allowed at Bank.



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Patient Registration - Please fill out form completely. All information required.

PATIENT INFORMATION:

Last name: ____________________ First name: ____________________ M.I.: ______

Street address: ____________________

City: ____________________ State: ____________ Zip: ____________

Date of Birth: ____________________ Social Security Number: ____________________

Marital status: ☐ Single ☐ Married   Children: ☐ Yes ☐ No

EMERGENCY CONTACT INFORMATION:

Emergency Contact Name: ____________________ Your relationship to contact: ____________

Emergency Contact phone number, including area code: (   ) ____________________

PLEASE GIVE ALL PATIENT CONTACT PHONE NUMBERS, INCLUDING AREA CODES:

Home: (   ) ____________ Work: (   ) ____________ Cell: (   ) ____________

Preferred phone number for scheduled appointment reminder calls? ☐ Home ☐ Work ☐ Cell

WORK INFORMATION:

Employer/Company Name: ____________________

Occupation: ____________________ Hours per week: ____________

HOW DID YOU FIND OUT ABOUT US?

☐ Friend / Relative (Name? ____________) ☐ Walked / Drove By Clinic ☐ Radio Ad

☐ Referred by Doctor / Nurse / Healthcare Practitioner (Name? ____________) ☐ Phone book

☐ Brochure (where? ____________________) ☐ Other: ____________________

INSURANCE INFORMATION REGARDING INJURY - FILL OUT ONE OF THE THREE OPTIONS

1. ON THE JOB INJURY? ☐ Yes ☐ No (If yes, provide Worker's Compensation/L & I Information:)

a. Insurance Company Where Claim is Filed: ____________________

b. Claim Number: ____________________

c. Date of Injury: ____________________

d. Adjustor or Claim Manager's Name: ____________________

e. Adjustor or Claim Manager's Phone Number: ____________________

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INSURANCE INFORMATION CONTINUED - FILL OUT ONE OF THE THREE OPTIONS COMPLETELY.

2. DOES THE INJURY APPLY TOWARD YOUR AUTO POLICY (PIP)? ☐ Yes ☐ No

If yes, please provide the following information:

a. Auto Insurance Company Where Claim is Filed: ______________________

b. Claim Number: ______________________

c. Date of Injury: ______________________

d. Auto Injury Adjustor or Claim Manager's Name: ______________________

e. Adjustor or Claim Manager's Phone Number: (   ) ______________________

f. Are subrogation papers filed with your private insurance company? (i.e. BCBS, Aetna, etc.)
☐Yes ☐No ***If yes, please fill out Option 3 below as well***.

3. IF THE INJURY/SYMPTOMS ARE NOT WORKER'S COMPENSATION, L & I, OR AUTO RELATED, PROVIDE PRIMARY INSURANCE INFORMATION WHERE CLAIMS ARE TO BE SUBMITTED:

a. Insurance Company Name: ______________________

b. Customer Service Telephone: ______________________

c. ID Number: ______________________

d. Group Number: ______________________

e. Subscriber Name: ______________________

f. Please circle the relationship of the subscriber:

Self   Spouse   Parent   Guardian   Other

If the subscriber is someone other than yourself, please provide the following information:

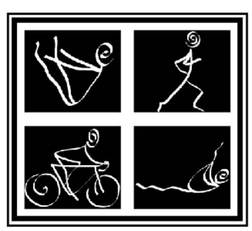
g. Subscriber's Birth Date: __________ h. Subscriber's Social Security Number: __________

i. Subscriber's Employer/Company Name: ______________________

j. Subscriber's Work phone, including area code: (   ) ______________________

I, the undersigned, certify that my dependent or I have insurance coverage with the insurance company I have listed and assign directly to Bodies in Balance all insurance benefits. I understand that I am financially responsible for all charges that are not payable or are denied by my insurance company. By signing, I authorize my medical information to be released to the insurance company listed above.

Sign: ______________________ Date: ______________



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Patient Registration - Please fill out form completely. All information required.

As a patient of Bodies in Balance Physical Therapy, PLLC, there may be occasions where the office may need to contact you regarding appointments. Please tell us how you would like to be contacted.

I give permission for Bodies in Balance to leave voice messages on the following numbers:

- ☐ Work voice mail
- ☐ Home voice mail
- ☐ Cell voice mail
- ☐ Do Not leave a voice mail

In such an event, if I am unavailable, I authorize Bodies in Balance and staff to discuss my appointments with the following individuals (ex. my secretary, Jane Doe) or leave a voice mail message.

I give Bodies in Balance permission to discuss this information with the following individuals.

Name: ______________________ Relationship: ______________________

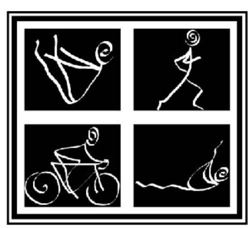
Name: ______________________ Relationship: ______________________

Name: ______________________ Relationship: ______________________

Name: ______________________ Relationship: ______________________

I understand that I may revoke this authorization at any time by notifying the office in writing of my desire to do so.

Sign: ______________________________ Date: ______________



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Appointment Confirmation, Cancellation and Billing Policy

Courtesy Calls:
We generally make appointment reminder calls. However, if you do not receive a call from us, this does not mean you do not have an appointment. Please contact us promptly if you have any scheduling questions.

Appointment Scheduling:
Patients are seen by appointment on a first come, first serve basis. As a small specialty private practice in orthopedic manual physical therapy, we see one patient per hour. Please schedule your appointments 6 to 8 weeks in advance, since our schedule is typically full two to three weeks ahead.

Appointment Start Times:
If you are going to be more than 15 minutes late, please call our office as soon as possible. Your appointment may require rescheduling.

Appointment Cancellations and Fees:
In the event that you need to cancel an appointment, we require 24 hours notice on business days Monday thru Friday. (For example: to cancel an appointment on Monday, the call must be received on the proceeding Friday.) The charge for a late cancellation is $100 for an initial visit and $85 for a subsequent visit. This charge will show up on monthly statements for those who receive insurance billing services, and is due at the next billing cycle. The fee is due immediately from our fee-for-service patients. The cancellation charge is the sole responsibility of the patient. Insurance carriers will not pay for missed or cancelled appointments. Late cancellation due to illness is excluded from this policy per the discretion of the therapist.

Billing Policy:
We are not able to provide you with an exact billing amount for services rendered **before** your scheduled appointment(s). We cannot predict what will be treated during each session. We can only give you an estimate. Please keep in mind that your treatment plan is specific to your situation. Therefore, your bill for each treatment may vary. An estimated quote **is not in any way a guarantee** of what your final bill will reflect.

Reading and signing this policy confirms that you will comply with this policy.

I have read and understand the above policies.

Sign:____Date: ____________

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Patient Registration: Medical History

Patient last name: ________________________ Patient first name: ________________________ M.I.: _____

Date of Birth: ____________ Doctor: ____________________________________ Today's Date: __________

Condition/Diagnosis: ____

Medication Allergies: ____

Current Medications: ____

Please answer the following questions about your medical history:

Osteoporosis / Brittle bones?	Y / N	Neuropathies / nerve problems?	Y / N
Long term use of Prednisone?	Y / N	Lung Disease/ Asthma?	Y / N
Heart Disease?	Y / N	Rheumatoid arthritis?	Y / N
Hypertension?	Y / N	Thyroid problems?	Y / N
Pacemaker?	Y / N	Strokes / head injury?	Y / N
Diabetes / Blood sugar problems?	Y / N	Ulcers / Stomach problems?	Y / N
Seizures / Epilepsy?	Y / N	Kidney / Liver problems?	Y / N
Metal Implants?	Y / N	Anemia?	Y / N
Skin Allergies to tape or beeswax?	Y / N	Prio Injuries to spine?	Y / N
Hemophilia / Bleeding problems?	Y / N	Prior Fractures?	Y / N
Currently on blood thinners?	Y / N	Previous surgeries? (list below)	Y / N
Incontinence / Leaky bladder?	Y / N	Cancer? (list below) Date diagnosed__________	Y / N
Circulation problems?	Y / N	Other problems not listed?	Y / N

Details from above: ____

Are you right or left handed?	R / L	Do you smoke currently? If yes, packs per day: _______________	Y / N
How many alcoholic drinks, beers, and glasses of wine do you consume in an average week? Is this part of your pain control?	____ Y / N	If no, have you smoked in the past? Packs per day: _____________________	Y / N
Beyond your regular chores, how long (in hours) do you exercise in an average week?	____	Are you having trouble with basic mobility in or around your home such as stair, ramps, or uneven terrain?	Y / N
Are you having trouble with managing your home chores, driving, shopping, child care, etc.?	Y / N	Are you having trouble with dressing or bathing?	Y / N
Have you had one or more major life stresses in the last year? (death of a loved one, birth of child, moving, job change, etc.)	Y / N	Is there a history of any serious medical conditions (heart disease, cancer, diabetes, etc.) in your immediate family (parents or siblings)?	Y / N
Do you have problems seeing? Do you have Bi or Tri focals?	Y / N Y / N	Have you had your vision checked in the last 2 years?	Y / N

Details from above: ____

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Patient Registration: Medical History, continued

Within the last 6 months, have you had any of the following symptoms?

Chest pain?	Y / N	Pain at night?	Y / N
Dizziness?	Y / N	Unexpected weight gain or loss?	Y / N
Blackouts?	Y / N	Fever, chills, night sweats?	Y / N
Headaches?	Y / N	Numbness or tingling in your face, arms or legs?	Y / N
Loss of balance / fainting?	Y / N	Urinary problems?	Y / N

Details from above: ____________________

WOMEN:

Are you (or do you think you might be) pregnant?	Y / N
Number of pregnancies?	
Number of births?	
Have you had a pelvic/gynecological exam in the last two years?	Y / N
Do you have pelvic inflammatory disease, endometriosis, or trouble with your period?	Y / N
Do your current symptoms vary with your menstrual period? (if applicable)	Y / N
WOMEN OVER 45 YEARS: Have you ever had a mammogram?	Y / N
WOMEN OVER 50 YEARS: Have you ever had a colon cancer screen?	Y / N
If yes, was the screen during the last 3 years?	Y / N
Have you had a mammogram in the last 2 years?	Y / N

MEN OVER 50 YEARS:

Have you ever had your prostate checked?	Y / N
If yes, was the screen during the last 3 years?	Y / N
Have you ever had a colon cancer screen?	Y / N
If yes, was the screen during the last 2 years?	Y / N

HISTORY OF CURRENT PROBLEM

1. When did this problem start?: ____________________
2. Was this due to a car accident? ☐ Yes ☐ No If Yes, Date: ____________________
3. Was this due to a work injury? ☐ Yes ☐ No If Yes, Date: ____________________
4. Tests performed (check all that apply): ☐ X-Ray ☐ MRI ☐ Other ☐ None
   a. Results from above tests, if known: ____________________
5. Have you had physical therapy before? ☐ Yes ☐ No a. If yes, when (approximately)? __________
   b. For what problem? ____________________
6. Other than the doctor who sent you here, are you seeing another practitioner for this or a related problem? (massage therapy, chiropractor, osteopath, athletic trainer, etc.) ☐ Yes ☐ No
   a. If yes, what type of treatment(s) are you receiving? ____________________

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Patient Registration: Subjective Evaluation

ANSWER ALL QUESTIONS AS THOROUGHLY AS POSSIBLE. THE INFORMATION YOU PROVIDE WILL ASSIST IN EVALUATING YOUR CONDITION.

SUBJECTIVE EVALUATION OF YOUR SYMPTOMS

1. What is (are) your chief complaint(s)? ____________________

____

2. How did your problems begin (e.g. injury, gradual onset, unknown)?

____

____

3. Was surgery performed to treat this problem? ☐ Yes ☐ No

   a. If yes, what was the surgery, and when? ____________________

4. At this time, are you getting: ☐ Better ☐ Worse ☐ Unchanged

5. Have you had previous episodes of this problem? ☐ Yes ☐ No

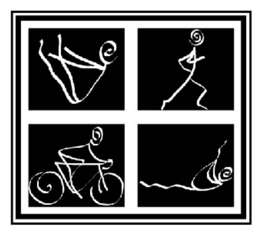
   a. If yes, please describe them: ____________________

____

6. Do you have orthopedic problems? ☐ Yes ☐ No

   a. If yes, please describe them: ____________________

____



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Patient Registration: Subjective Evaluation, continued

NATURE AND IRRITABILITY OF SYMPTOMS

1. On a scale of 0 to 10 (10 being the worst), rate your symptoms: _______at Worst ______at Best

2. What makes your symptoms worse? (check all that apply)

☐ Sitting ☐ Walking ☐ Standing ☐ Bending ☐ Lifting

☐ Squatting ☐ Lying Down ☐ Stress ☐ Prolonged Positions

a. How long can you perform these tasks? (circle which applies)

☐ Sitting for ____________ minutes / hour(s) ☐ Standing for ____________ minutes / hour(s)

☐ Walking for __________ minutes / hour(s) ☐ Lying Down for _________ minutes / hour(s)

☐ Changing Positions ☐ Other ____

3. What makes your symptoms better? (check all that apply)

☐ Sitting ☐ Walking ☐ Standing ☐ Exercise ☐ Ice ☐ Heat ☐ Medications

☐ Lying Down If you checked Lying Down, in what position are your symptoms better? _____________

☐ Other If you checked Other, please describe: ____

____

4. Are your symptoms best in the (check): ☐ Morning ☐ Mid-Day ☐ Evening

5. Are your symptoms worse in the (check): ☐ Morning ☐ Mid-Day ☐ Evening

6. PAIN CHART: Using the diagram below, mark the areas on your body where you feel the sensations described below. Using the appropriate symbol, mark the areas of radiating pain, and include the affected areas. Please mark an "X" on the body diagrams for where the pain is worst now.

Aching
▲▲▲

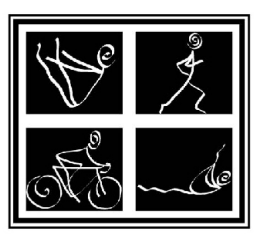
Numbness
===

Pins and needles
● ● ●

Burning
✔✔✔

Stabbing
///

Front Left Side Right Side Back



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Patient Registration: Subjective Evaluation, continued

FUNCTIONAL STATUS

1. Are you currently working? ☐ Yes ☐ No Occupation ______________ Hrs/Wk __________

    a. If yes, describe the physical demands of your job and how your current problem(s) affect your job performance: ____________________

    ____

2. Prior to the onset of this problem, did you engage in regular exercise? ☐ Yes ☐ No

    a. If yes, please list the type of exercise you <u>used to</u> perform, frequency, and how your current problem(s) affect your ability to continue to exercise: ____________________

    ____

3. Is your current problem(s) affecting your (check all that apply):

    ☐ Social Life ☐ Family Life ☐ Societal Duties

    ☐ Parenting Duties ☐ Household Duties ☐ Other

    a. If yes, please describe: ____________________

    ____

4. List, in prioritized order, your goals for physical therapy. Please be as specific as possible. Include goals relating to work, recreation, fitness, household duties, parenting duties, etc. (e.g. able to sit at my computer for one hour at a time without neck pain):

    ____

    ____

5. What is the amount of time and days per week you are willing to invest to meet these goals? __________

    ____

This information is complete and accurate to the best of my knowledge.

Sign: ______________________________ Date: ______________

Thank you for completing this questionnaire. Your complete answers will allow more of your evaluation time to be spent on tests and procedures to assist in the diagnosis of your problem(s) that are treatable with physical therapy. Please call our office at 423.255.6105 if you have any questions prior to your appointment.

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Notice of Privacy Practices

The document describes how medical information about you is utilized within this office and may be disclosed and how you can obtain access to the information. This notice explains how we may use and share medical information about you. We describe your rights and certain duties we have regarding the use and disclosure of medical information. The rules are required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

1. OUR LEGAL RESPONSIBILITIES

- To maintain the privacy of your protected health information
- To provide you with notice of our legal duties and privacy practices with respect to protected health information effective April 1, 2003
- To abide by the terms of the Notice of Privacy Practices and to make the new notice changes effective for all protected health information that we maintain
- To provide you with a written copy of the Notice of Privacy Practice and any revised notices from our office at your next scheduled visit

2. UNDERSTANDING YOUR MEDICAL RECORD INFORMATION

The privacy of your medical information is important to Bodies in Balance, its employees, and its contractors. Upon your first visit, we create a record of the care and services you receive at our organization. This record contains information regarding your examination, diagnosis, test results, treatment as well as other pertinent health care data. We utilize this record to:

- Provide you with quality care and to comply with certain legal requirements
- Plan and describe your treatment received
- Provide to your insurance company to verify services billed prior to paying for services rendered
- Ensure quality of service and patient satisfaction, to evaluate the performance of employees/ contractors and for training in-services
- To communicate with your physician, massage therapist, or other people providing health care services

3. YOUR RIGHTS

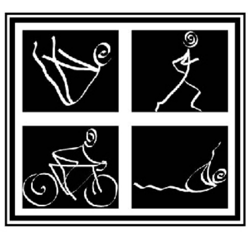
You have certain rights under the federal privacy standards. These include your rights to:

- Request restrictions on certain uses and releases of protected health information including those related to releases to family members, other relatives, close personal friends or any other person identified by you. We are, however, required to notify you if we disagree with a requested restriction.
- Requests to receive private communications of protected health information from us by different means or at different locations
- Review and request a copy of your protected health information outside of treatment at this facility

If you feel your privacy has been violated, file a complaint with Lisa M. Fox, President and Co-Owner of Bodies in Balance Physical Therapy, PLLC by calling 423.255.6105. We will not penalize or discriminate against you for filing a complaint. If you have questions or think we may have violated your privacy, send a written complaint to the US Department of Health & Human Services. We will provide you with the address to file your complaint. We will not retaliate in any way if you choose to file a complaint.

By signing this document, I agree I have received a copy of and to have read the above notice.

Sign: ____ Date: ______________



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- Provide to your insurance company to verify services billed prior to paying for services rendered
- Ensure quality of service and patient satisfaction, to evaluate the performance of employees/ contractors and for training in-services
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You have certain rights under the federal privacy standards. These include your rights to:

- Request restrictions on certain uses and releases of protected health information including those related to releases to family members, other relatives, close personal friends or any other person identified by you. We are, however, required to notify you if we disagree with a requested restriction.
- Requests to receive private communications of protected health information from us by different means or at different locations
- Review and request a copy of your protected health information outside of treatment at this facility

If you feel your privacy has been violated, file a complaint with Lisa M. Fox, President and Co-Owner of Bodies in Balance Physical Therapy, PLLC by calling 423.255.6105. We will not penalize or discriminate against you for filing a complaint. If you have questions or think we may have violated your privacy, send a written complaint to the US Department of Health & Human Services. We will provide you with the address to file your complaint. We will not retaliate in any way if you choose to file a complaint.

By signing this document, I agree I have received a copy of and to have read the above notice.

Sign: ____ Date: ____________