BALANCE INSTITUTE OF INDIANA

Phone (317)577-7333 Fax (317)577-7330

Confidential Medical History/Evaluation

Name: _____ **Today's Date:**___/___/___ **Date of Birth :**___/___/___

Occupation: _____ **Is this injury?** Work Related or Auto Accident **Date of Injury:** ___/___/___

Describe injury: _____

Are you currently seeing a Physical Therapist? YES (or) NO **If so, for what condition:** _____

What are your symptoms: _____ **When did all of this begin:** _____

Condition: (circle) Acute - Chronic - Constant - Comes and Goes - Spells/Attack

Current Symptoms: (circle) Aching - Burning - Cramping - Deep - Dull - Heavy - Numbness - Stabbing - Throbbing - Weakness - Lightheaded - Vomiting - Nausea - Unsteady walking/standing - Headaches - Woozy - Pressure - Spinning - Jumping vision - Rocking sensation - Sense of leaning/tilting - Frequent falling - Staggering - Disorientation - Blurry/Double Vision - False sense of self motion - False sense/visual surround is moving - Occurs after a change in head/body position - Triggered by complex or large moving visual stimulus

Ears: (circle) Ringing - Popping - Fullness - Pain **Hearing loss:** R L *** **Pain:** Jaw - Neck - Back ***RATE Pain: _____/10

How long do symptoms last? SECONDS - MINUTES - HOURS - DAYS

How frequent do the symptoms occur? _____

When was your last spell? _____

How many times have you fallen in the past 6-12 months? _____

What Injuries occurred? _____

When was your last fall? _____ **Describe your last fall:** _____

Any Diagnostic Testing for this Injury?

MRI MRA X-rays CT scan EKG EMG VNG Audiogram Blood work Rotary chair VEMP

Other: _____

Circumstances that may cause/increase your symptoms? (Circle all that apply)

Sudden Movement	Passing traffic/Trains	Yard Work	Looking out a car window
Blowing nose	Menstrual Cyle	Coughing/Straining	Bright lights
Concentration	Bending/Leaning down	Grocery/Mall Aisle	Turning Head R or L
Rolling over in bed	Physical exertion	Stress/Fatigue	Driving/Riding in car
Reading	Walking in the dark	TV/Computer	Prolonged Sitting/Standing

Additional Medical History (Circle all that apply)

Anxiety	Concussion	Falling	Defibrillator	Head Injury
Memory Loss	Motion Sickness	MS	Panic Attacks	Punctured Ear Drum

What are you unable to do because of your balance issues: _____

WHAT IS YOUR SHOE SIZE: _____

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Patient Name: _____ SSN#_____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( )_____ Cell Phone: ( ) _____

Work Phone: ( ) _____ _____ E- MAIL : _____

Primary Insurance Policy Holder's Name: _____ DOB: _____ SSN# (if not the patient): _____

Emergency Contact: _____ **Phone Number:** _____

RELEASE OF MEDICAL INFORMATION: _____ **initials**

I authorize Balance Institute of Indiana to release medical records concerning myself/son/daughter/other dependent to any physician, hospital, individual or agency involved in the care of the patient listed below. Please release my records to the ***NON-REFERRING*** practitioner or other listed below. (This request will expire in 6 months from date of signature.)

Physician/Other: _____ ____ **Please send this doctor a copy of my notes**

Address: _____

Phone/Fax: _____

ASSIGNMENT OF BENEFITS: _____ **initials**

I authorize my insurance carrier to assign medical benefits to Balance Institute of Indiana. I also authorize release of medical information necessary to process all medical insurance claims. **I understand I am responsible to inform the Balance Institute of Indiana office of any changes that occur, including but not limited to, change in insurance carrier.**

PAYMENT POLICY: _____ **initials**

Co-payments are due at the time services are received. We accept cash, check, and credit cards. All medical services provided are directly charged to the patient or responsible party. If our clinic is contracted with your insurance carrier, we will accept its negotiated rate for the charges billed. However, you will be responsible for any balance deemed patient responsibility/non-payable/non-covered by your insurance company and billed accordingly. Payment is expected in full upon receipt of statement or payment arrangements must be made with our billing office **PRIOR** to services. A ***$5.00 fee*** will be due on your initial visit for education supplies you may receive. **Should I, the patient, default on my financial responsibility and collection action is necessary, I will be responsible for the collection costs, including attorney fees that are incurred. I am aware a *$35.00 fee* will be assessed to all checks submitted with non-sufficient funds.**

CANCELLATION/NO SHOW POLICY: _____ **initials**

Our office requires **a 24 hour notice of cancellation**. We have 24 hour voice mail to assist with this. Cancellations and no show fees are the patient's responsibility and will NOT be billed to your insurance. Fee payments are due on or before your NEXT appointment. **I, the patient, agree to pay a *$50.00 fee* for each late cancellation or no show appointment.**

BII MEDICAL WELLNESS RECOMMENDATIONS: _____ **initials**

I am aware and have received the BII Wellness Recommendations with my New Patient Paperwork

HIPAA: _____ **initials**

I acknowledge that I have seen the "Notice of Privacy Practices". I understand that I may ask questions about the "Notice of Privacy Practices" at any time.

I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION, PAYMENT POLICIES, AND CLINIC POLICIES:

X: _____ X: _____

Signature of Responsible Party **Date, Read and Signed**

PLEASE ANSWER AS IT RELATES TO YOUR CONFIDENCE WITH YOUR BALANCE AS OF TODAY

For each activity, please indicate your level of confidence by choosing a corresponding percentage from the following.

ZERO being will fall and 100% being completely safe in the activity

WILL FALL 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% ***SAFE***

Walking around the house? _____%
Walking up or down stairs? _____%
Bending over and picking up a slipper from the front of the closest/floor? _____%
Reaching for a small can on a shelf at eye level? _____%
Standing on your tip toes and reaching for something above your head? _____%
Standing on a chair and reaching for something? _____%
Sweeping the floor? _____%
Walking outside of the house to a car parked in the driveway? _____%
Getting into and out of a car? _____%
Walking across a parking lot to the mall? _____%
Walking up or down a ramp? _____%
Walking in a crowded mall where people rapidly walk past you? _____%
When bumped into by people as you are walking through the mall? _____%
Stepping onto or off an escalator while you are holding onto a railing? _____%
Step onto or off an escalator holding onto parcels such that you cannot hold onto railing? _____%
Walking outside on icy sidewalks? _____%

PATIENT'S NAME: _____

DATE OF BIRTH: _____

TODAY'S DATE: _____

OVER

Telehealth Visit Permission to Treat

I, _____ (Print name), consent to participating in a telehealth visit with a Physical Therapist, who is an employee of Balance Institute of Indiana. I understand that the evaluation and treatment of current medical condition(s) using a synchronous video and/or audio call is under the Physical Therapy scope of practice similar to a clinic visit and will be carried out by a licensed practitioner.

I understand that the telehealth session will use Zoom, a computer application that allows for encrypted video meetings. Encrypted meetings are private meetings between the Physical Therapist and the patient that keeps health information on a secure line, prevents hacking, and reduces invasion of privacy. I understand that the version of Zoom used for telehealth visits does not have a business contact to be HIPAA compliant, however, Zoom does follow HIPAA guidelines to ensure private health information is kept secure throughout the session. This private health information is not stored after completion. No recording of the session will be done unless verbal consent is given.

I understand the Physical Therapist will conduct the session in a space that is conducive for keeping health information private and maintain professional guidelines. I understand that no physical exam or manual therapy will be given during a telehealth visit and I agree to the Therapist's plan of care that may be modified for telehealth.

I have also signed the general consent form for treatment from the clinic, Balance Institute of Indiana. The current clinic policies apply to telehealth visits as well.

_____ _____

Signature Date

_____ _____

Witness Date

Balance Institute
of Indiana

Dedicated to the Evaluation, Treatment, and Research of Balance Impairments

CREDIT CARD AUTHORIZATION

Please complete the form as completely as possible. This authorization can be withdrawn at any time.

Credit Card Information

Credit Card Company:

☐ Mastercard

☐ Visa

☐ Discover

Cardholder's Name (as written on the card): _____

Card Number: _____

Expire Date: _____

Billing Information:

Address: _____

City: _____

State: _____

ZIP Code: _____

Phone: _____

By Signing this form:

1) I authorize **Balance Institute of Indiana** to charge this card. I may choose to use other forms of payment such as cash or check. I understand that should my account be 30 days overdue; I authorize **Balance Institute of Indiana** to automatically charge this card.

2) I hereby grant permission to charge by credit card if there is an outstanding balance on my account without further authorization.

Authorized Signature: _____ Date: _____

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6249 South East Street, Suite C • Indianapolis, IN 46227 | **PHONE:** (317) 783-1295 **FAX:** (317) 783-0633