FINANCIAL POLICY

As a courtesy, we call your insurance company to verify physical therapy benefits. Below is a summary of the information given. **PLEASE NOTE THAT THIS IS NOT A GUARANTEE OF PAYMENT.** We encourage you to also call your insurance company to verify your physical therapy benefits.

- ❑ Copay: _____
- ❑ Coinsurance: _____% per visit
  Your coinsurance amount will be collected at the time of your visit.
- ❑ Deductible: _____Deductible Met: _____Balance: ____

You remain responsible for payment in full to Berkeley Community Physical Therapy, Inc. if your insurance company denies or delays payment for more than 30 days from the date your claim was billed.

24 hour cancellation policy: A $120 new evaluation or $60.00 follow up appointment no show/late cancel fee will be billed directly to you. Two consecutive no shows may result in the removal of future appointments from the schedule.

WORKERS' COMP PATIENTS: You are not required to pay for your physical therapy visits if you have authorization from your workers' compensation insurance company. If your workers' comp carrier will not authorize treatment, you have the option of paying for each visit or having us bill your health insurance.

AUTO ACCIDENT PATIENTS: If your auto insurance covers medical payments and you can provide us with the pertinent information to verify coverage, we will bill your auto insurance company for you. We do not accept liens.

PRIVATE/SELF PAY PATIENTS: You are required to pay in full for each visit.

I have read and agree to the terms stated above. I understand that I am ultimately responsible for any amount not covered by my insurance company.

_____ _____
Signature Date

_____
Print Name

BERKELEY COMMUNITY PHYSICAL THERAPY, INC.

DATE_____ REFERRING PHYSICIAN_____

PATIENT INFORMATION

Last Name_____First_____M.I,_____

Are you known by any other name? ☐ Yes, Name_____ ☐ No

Address_____ City_____ State ____ Zip_____

Home Phone_____ Cell_____ Work_____

Date of Birth_____ Sex ☐M ☐F Driver's Lic. #_____

Marital Status: ☐M ☐S ☐D ☐W ☐DP Spouse/DP Name_____

In case of emergency, notify:_____ Relation_____Phone #_____

Is this a work related injury? ☐ Yes ☐ No Date of Injury_____

Is this an accident related injury? ☐ Yes ☐ No Date of Injury_____

If an attorney is involved, name of attorney_____

PRIMARY INSURANCE INFORMATION

Primary Insured Name_____ DOB of Insured_____

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child

Group #_____ Certificate # or ID # (incl 3 letter prefix) _____

Insurance Company Name _____

Billing Address _____

City_____ State_____ Zip_____ Phone_____

SECONDARY INSURANCE

Name of Insured_____ Relationship_____

Insurance Co. Name_____ Group #_____

Address_____ Phone_____

City_____ State_____ Zip_____

AUTO INSURANCE INFORMATION

Name of Insured_____ Relationship_____

Insurance Co. Name_____ Group #_____

Address_____ Phone_____

City_____ State_____ Zip_____

Claim #_____ Adjustor Name_____

WORKERS' COMPENSATION INFORMATION

Employer's Name (at time of injury)_____

Insurance Co. Name_____

Address_____ Phone_____

City_____ State_____ Zip_____

Claim #_____ Adjustor Name_____

ATTORNEY INFORMATION

Name _____

Firm_____

Address_____ Phone_____

City_____ State_____ Zip_____

BERKELEY COMMUNITY PHYSICAL THERAPY, INC.

PATIENT INFORMATION CONSENT FORM

I have read and fully understand Berkeley Community Physical Therapy, Inc.'s "Notice of Patient Information Practices". I understand that Berkeley Community Physical Therapy, Inc. may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Berkeley Community Physical Therapy, Inc. will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Berkeley Community Physical Therapy, Inc.'s "Notice of Patient Information Practices." I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____ _____

Signature Date

_____

Patient Name (print)

ASSIGNMENT OF BENEFITS

Authorization of pay Berkeley Community Physical Therapy, Inc.

I hereby authorize my insurance benefits to be paid directly to Berkeley Community Physical Therapy, Inc. and I am financially responsible for copays, coinsurance amounts, and non-covered services. I also authorize Berkeley Community Physical Therapy, Inc. to release any information requested to process this claim.

**Payments are due within 30 days. Late payments are subject to 1.5% finance charge per month.

_____ _____

Signature Date

BERKELEY COMMUNITY PHYSICAL THERAPY, INC.

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

BERKELEY COMMUNITY PHYSICAL THERAPY, INC.'S LEGAL DUTY

Berkeley Community Physical Therapy, Inc. is required by law to protect the privacy of your personal health information, to provide this notice about our information practices and to follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Berkeley Community Physical Therapy, Inc. uses your personal health information primarily for treatment, to obtain payment for treatment, to conduct internal administrative activities and to evaluate the quality of care that we provide. For example, Berkeley Community Physical Therapy, Inc. may use your personal health information to contact you to provide appointment reminders, information about treatment alternatives or health related benefits that could be of interest to you.

Berkeley Community Physical Therapy, Inc. may also use or disclose your personal health information without prior authorization for public health purposes, auditing purposes, research studies, and emergencies. We also provide information when required by law.

In any other situation, Berkeley Community Physical Therapy, Inc.'s policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Berkeley Community Physical Therapy, Inc. may change its policy at any time. When changes are made, a new Notice of Patient Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Patient Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Berkeley Community Physical Therapy, Inc. will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Berkeley Community Physical Therapy, Inc. may have violated your privacy rights or if you disagree with any decision we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. For further information on Berkeley Community Physical Therapy, Inc.'s health information practices or if you have a complaint, please contact the following person:

Janet Yamada Soto, P.T.
2041 Bancroft Way, Suite 301
Berkeley, CA 94704
510-549-2225

BERKELEY COMMUNITY PHYSICAL THERAPY, INC.

HEALTH HISTORY QUESTIONNAIRE

Name_____ Date_____

1. Do you consider your health to be: ♡ Excellent ☆Good ❍ Fair ☹ Poor

2. Please indicate if you have or have had any of the following:

- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding disorders
- ❑ Cancer
- ❑ Diabetes
- ❑ Gastrointestinal disorders
- ❑ Head trauma
- ❑ Headaches
- ❑ Heart attack
- ❑ Heart disease
- ❑ Hernia
- ❑ Hypertension
- ❑ Kidney or bladder disorders
- ❑ Liver disorders
- ❑ Lung disease
- ❑ Osteopenia/osteoporosis
- ❑ Seizures/nervous disorders
- ❑ Ulcers
- ❑ Visual disturbances

3. Do you have any health problems not mentioned above? Please explain:

_____

4. Do you have implants such as joint replacements or pacemaker? □ YES □ NO

5. Have you ever had surgery? □ YES □ NO If yes, please describe:

_____

6. Have you been in any accidents, motor vehicle or other? □ YES □ NO
If yes, please explain:

_____

7. Do you use supports such as shoe lifts, orthotics, or a corset? □ YES □ NO
If yes, which one(s):

_____

8. Please list any medications, including dosages, that you are currently taking:

_____

9. WOMEN: Are you pregnant? □ YES □ NO