

Thank you for scheduling with Berkeley Physical Therapy!

PLEASE READ ALL OF THE FOLLOWING INFORMATION.

Your first appointment is on _____ at _____ with_____.

24 HOUR CANCELLATION POLICY: a \$55.00 no show/ late cancel fee will be billed directly to the patient. Please be advised that 2 CONSECUTIVE NO SHOWS may result in the removal of future appointments from the schedule.

Be prepared to expose the area to be treated, i.e. bring shorts for a leg or knee injury and women, bring a halter or bathing suit top for shoulder and back injuries.

If you have had recent surgery, x-rays or MRI, please bring a copy of the surgical report or x-ray/MRI findings. Please request these reports from your physician prior to your initial consultation at Berkeley Physical Therapy.

Enclosed are several forms for you to fill out and bring completed to your first visit. In addition, please bring:

1. Your insurance card (except those patients on worker's compensation or using automobile insurance.
2. The physician referral for physical therapy if required by your insurance.

Our address is 2041 Bancroft Way, Suite 301 at the corner of Shattuck Avenue, above the Pasand Restaurant. One hour metered parking is available on Bancroft Way, and one and a half hour parking is available on Shattuck Avenue. A public parking lot is located on Kittredge between Milvia and Shattuck Avenues. Berkeley Physical Therapy does not validate parking.

STREET LEVEL DOOR CODE: Push the **RED BUTTON**, pause, # (**pound**) sign, **2484**, in that order and the front door will unlock.

COPAYS AND OFFICE VISIT FEES ARE DUE AT THE TIME OF EACH VISIT AND ARE PAYABLE BY CASH, CHECK OR CREDIT CARD (MasterCard, VISA, Discover).

We look forward to seeing you soon!

BERKELEY 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 PHYSICAL THERAPY, INC.'s LEGAL DUTY

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

USES AND DISCLOSURES OF HEALTH INFORMATION

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

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

In any other situation, Berkeley 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 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 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 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 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
(Telephone) 510-549-2225 (Fax) 510-549-0741

BERKELEY PHYSICAL THERAPY, INC.

DATE _____ REFERRING PHYSICIAN _____

PATIENT INFORMATION

Last Name _____ First _____ M.I. _____

Are you known by any other name? YES NO If yes, what name? _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Date of Birth _____ Sex: M F SSN _____ Driver's Lic. # _____

Marital Status: M S D DP Spouse/DP Name _____

In case of emergency, notify: _____ Relation _____ Phone # _____

Is this a work related injury? YES NO If yes, date of injury _____

Is this an accident related injury? YES NO If yes, date of injury _____

Is an attorney involved? YES NO If yes, name of attorney _____

PATIENT WORK INFORMATION

Employer's Name _____

Address _____ City _____ State _____ Zip _____

Work Phone # _____ Empl. ID# _____ Occupation _____

MEDICARE INFORMATION

Medicare Number as shown on Medicare Card _____

PRIVATE INSURANCE INFORMATION

Who is the primary insured? Self Other (name) _____

Your relationship to the insured _____

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

Insurance Company Name _____

Billing Address _____

City _____ State _____ Zip _____

Phone # (customer service) _____ **NEXT PAGE----->>>>**

SECONDARY INSURANCE (Medicare Patients Only)

Name of Insured _____ Relationship _____ Group # _____

Insurance Co. Name _____ Phone # _____

Billing Address _____

City _____ State _____ Zip _____

AUTO INSURANCE INFORMATION

Name of Insured _____

Auto Insurance Co. Name _____ Phone # _____

Billing Address _____

City _____ State _____ Zip _____

Claim # _____ Adjustor Name _____

WORKERS' COMPENSATION INFORMATION

Employer's Name (at time of injury) _____

Workers Comp. Ins. Co. _____ Phone # _____

Billing Address _____

City _____ State _____ Zip _____

Claim # _____ Adjustor Name _____

ATTORNEY INFORMATION

Name _____ Phone # _____

Address _____

City _____ State _____ Zip _____

Authorization to pay Berkeley Physical Therapy, Inc.
ASSIGNMENT OF BENEFITS

I hereby authorize my insurance benefits to be paid directly to Berkeley Physical Therapy, Inc. and I am financially responsible for copays, coinsurance amounts, and non-covered services. I also authorize Berkeley 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.

SIGNED: _____ DATE _____

BERKELEY PHYSICAL THERAPY, INC.

PATIENT INFORMATION CONSENT FORM

I have read and fully understand Berkeley Physical Therapy, Inc.'s Notice of Patient Information Practices. I understand that Berkeley 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 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 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)

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 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 \$55.00 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.

CASH PAYING 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 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:

- | | |
|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Kidney or bladder disorders |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver disorders |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung disease |
| <input type="checkbox"/> Gastrointestinal disorders | <input type="checkbox"/> Osteopenia/osteoporosis |
| <input type="checkbox"/> Head trauma | <input type="checkbox"/> Seizures/nervous disorders |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Visual disturbances |
| <input type="checkbox"/> Heart disease | |

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 you are currently taking:

9. WOMEN: Are you pregnant? YES NO