

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 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.

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. Photo ID;
3. The physician referral for physical therapy;
4. Recent surgical, x-ray or MRI reports. (Request these reports from your physician prior to your initial consultation.)
5. List of medications and dosages.

**PARKING:** Our address is 2041 Bancroft Way, Suite 301 at the corner of Shattuck Avenue, above the former 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 **round CALL button**, pause, push the **# (pound) sign**, push **2484**, then push the **# (pound) sign** again in that order. The front door will unlock and a voice will say "access has been granted".

**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.

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 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)

### **ASSIGNMENT OF BENEFITS**

#### **Authorization of pay Berkeley Physical Therapy, Inc.**

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.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# **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, 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 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 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 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 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  
510-549-2225

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, including dosages, that you are currently taking:

\_\_\_\_\_

9. WOMEN:   Are you pregnant?    YES    NO