



Patient Intake Form

Patient Information

Patient Name: (First, MI, Last. – Sr., Jr., etc)				SS #:	
Address:		City		State	
Telephone:		Date of Birth (mm/dd/yy)		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Cell:				Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Other	
<i>Would you like to receive our newsletter via email?</i> <input type="checkbox"/> No <input type="checkbox"/> Yes – Email: _____					

Employer Information

Employer Name:		Work Phone #:		Employment Status: <input type="checkbox"/> None <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Self-Emp. <input type="checkbox"/> Retired <input type="checkbox"/> Student	
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Primary Insurance Information

Name of Insurance Company:		ID/#:		Group #/Employer:	
Policy Holder's Name:		Policy Holder's date of birth:		Patient Relationship to Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	

Secondary Insurance Information (if applicable)

Name of Insurance Company:		Policy / Claim #:		Group # / Policy Holders Employer:	
Policy Holder Name:		Date of Birth:		Patient Relationship to Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	

Emergency Contact Information

Contact Name:		Telephone #:		Relationship to Patient: <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Sibling <input type="checkbox"/> Other	
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For Workers Comp/Motor Vehicle Accident Claims

Original Date of Injury / Onset: Date: ____/____/____		Adjustor Name & Telephone # & Address: Name:			
Auto Related: <input type="checkbox"/> Yes <input type="checkbox"/> No		Work Related: <input type="checkbox"/> Yes <input type="checkbox"/> No		Phone: _____ Fax: _____	
		Claims address:			
If Workers Comp: Have you received Physical Therapy treatment for this condition since the above "Original Date of Injury"? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many treatment sessions have you completed? _____					
If Workers Comp, was accident with present employer? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, who was your employer? _____					



Medical History

Name _____

Age: _____ Height: _____ Weight: _____ Male / Female

Occupation: _____

Activities done at work: (example: sitting, lifting, standing, computer work, etc.)

What is your pain level? ___ / 10 (ten being severe pain)

Do you have/or have had any of the following:

	YES	NO		YES	NO
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Metal implants	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant (presently)	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease/Attack	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	History of smoking	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	Previous surgeries	<input type="checkbox"/>	<input type="checkbox"/>

If yes to any of the above, please explain as necessary:

In the present calendar year have you received any of the following:

Physical / Occupational Therapy / Chiropractic / Acupuncture care? Yes No

If yes, which type of treatment: _____ and how many sessions: _____. Was your treatment for the present injury or a different injury? If different please explain: _____

Excluding the previous question have you received any physical therapy in the past 5 years? Yes No

If yes, for what condition and when? _____

Current Medications:

Who referred you to B.E.S.T.? _____

Name of family or primary physician: _____

Patient Signature

Date



CONSENT AND CANCELLATION POLICY

CONSENT OF TREATMENT

I give my consent for B.E.S.T. Physical Therapy to furnish medical care and treatment considered to be necessary for my diagnosed condition.

RELEASE OF INFORMATION

I give permission to B.E.S.T. Physical Therapy to release information to my physician, insurance company, attorney, Assignees and/or Beneficiaries.

PATIENT INFORMATION CONSENT

I have read and fully understand B.E.S.T. Physical Therapy, Inc.'s Notice of Information Practices. I understand that B.E.S.T. Physical Therapy, Inc. may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, obtaining prescribed medical equipment from a vendor, 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 B.E.S.T. Physical Therapy, Inc. will consider requests for restriction on a case-by-case, 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 the B.E.S.T. Physical Therapy, Inc's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

INITIAL HERE → _____

CANCELLATION POLICY

Our goal is to give personal and quality care and an appointment time is your reserved time. We will make every effort to see you on time and request that you arrive on time for your reserved appointment. Thus, we request at least a 24-hour notice of cancellation or change of appointment. There will be a \$25.00 fee charged for any broken appointments without proper notice.

If calling to cancel during non-business hours, please leave a voice message with your name, therapist, and appointment date & time (408) 257-2225 or email bestphysicaltherapy@bestphysicaltherapy.com

PLEASE NOTE: All messages will not be received until 7 AM the next business day.

INITIAL HERE → _____

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES AND DISCLOSURES.

SIGNATURE

DATE



Medicare Benefits

Thank you for choosing B.E.S.T. Physical Therapy, Inc. to assist you with your medical needs. We trust that you will be fully satisfied with your decision. As a courtesy, we will be billing your insurance company on a weekly basis.

B.E.S.T. Physical Therapy does accept assignment with Medicare. However, Medicare will reimburse **80%** of usual and customary rates after your calendar year deductible has been met. If you have secondary insurance, B.E.S.T. will bill them directly as a courtesy. You will need to verify with your secondary insurance carrier if they will pay for services after the Medicare max has been met. Please supply us with all the necessary insurance information.

If you do not have secondary insurance or if your secondary is Medi-Cal (which we do not accept), then there will be a \$20.00 co-payment for each visit.

An itemized statement will be sent to you at the conclusion of your treatment. It is possible that your secondary insurance carrier will not pay beyond what Medicare has paid. In this case, your itemized statement will show the amount, which you need to pay to clear your account.

Effective January 1, 2010, Medicare is implementing a \$1,860.00 cap on outpatient physical therapy and speech pathology services with NO exceptions. This allows you approximately 15 visits per calendar year.

For additional information please contact Medicare at (800) 633-4227.

If any dates or charges are incorrect, please contact our office at (408) 257-2225 as soon as possible. **Please remember that billing your insurance company is a courtesy provided by B.E.S.T. and in no way relieves you of the responsibility of any balance on your account.** If you have any questions regarding your insurance benefits and/or limitations, please call your insurance company directly.

Sincerely,
B.E.S.T. Physical Therapy, Inc.

Patient Signature

Date



B.E.S.T. 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.

B.E.S.T. PHYSICAL THERAPY, INC., LEGAL DUTY

B.E.S.T. 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 AND HEALTH INFORMATION

B.E.S.T. Physical Therapy, Inc. uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities, obtaining prescribed medical devices from a vendor and evaluating the quality care that we provide. For example, B.E.S.T. 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.

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

In any other situation, B.E.S.T. 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.

B.E.S.T. Physical Therapy, Inc., may change its policy at any time. When changes are made, a new Notice of 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 Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

In most cases, you have the right to look at or get a copy of your personal health information. If you request copies, we will charge our standard fee. 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 information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. B.E.S.T. 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 B.E.S.T. Physical Therapy, Inc. may have violated your privacy rights or if you disagree with any decisions we may 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 US Department of Health and Human Services. For further information on B.E.S.T. Physical Therapy, Inc.'s health information practices, or if you have a complaint, please contact the following person:

Kathy Johnson, PT, OCS
B.E.S.T. Physical Therapy, Inc.

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