



Patient Intake Form

Patient Information			
Patient Name: (First, MI, Last. – Sr., Jr., etc)			SS #:
Address:	City	State	Zip
Home phone:	Date of Birth (mm/dd/yy)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	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
Cell:			
Would you like to receive appointment reminders via email? <input type="checkbox"/> No <input type="checkbox"/> Yes – Email: _____ Would you like to receive our newsletter via email? <input type="checkbox"/> No <input type="checkbox"/> Yes			

Emergency Contact Name: _____ Telephone #: _____

Relationship to Patient: Parent Spouse Sibling Other

For Workers Comp/Motor Vehicle Accident Claims ONLY			
Claim #:			
Referring Physician:		Diagnosis:	
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: Claims address:	Fax:
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? _____			

RELEASE OF INFORMATION I give permission to B.E.S.T. Physical Therapy to release information to my referring Physician, insurance company, Attorney, Assignees and/or Beneficiaries. **ASSIGNMENT OF BENEFITS** I authorize payment directly to B.E.S.T. Physical Therapy for services I receive. **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. **FINANCIAL RESPONSIBILITY** As a courtesy to you, we will bill your primary insurance carrier directly. *We do not* receive specific information on amounts of coverage or any guarantee of payment from your insurance carrier. *Ultimately*, YOU ARE RESPONSIBLE to pay for all services rendered to you regardless to what we may have been told by your insurance carrier. Your copayment/coinsurance is due at the time of service. We accept cash, check, or credit cards. **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 be here for your reserved time. **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.

I HAVE READ AND AGREE TO THE ABOVE TERMS, INSURANCE POLICIES AND DISCLOSURES.

Patient Signature

Date



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



B.E.S.T. PHYSICAL THERAPY FINANCIAL POLICY

Welcome to B.E.S.T. Physical Therapy, Inc. Everyone at B.E.S.T. is committed to providing you with the best possible care. If you have medical insurance, we will gladly submit your insurance claims for you. In order for us to do this we require that you provide us with a copy of the front and back of your insurance card and complete billing information. Incomplete billing information may lead to payment delays or your claims being denied by your insurance carrier. **The portion of your charges that are unpaid by your insurance carrier are your personal responsibility. It is your responsibility as the patient to know your own insurance coverage. Further we encourage you to contact your insurance carrier directly.**

IMPORTANT: A patient payment is expected at the time of service for any amount determined to be your estimated patient responsibility (i.e. percentage coverage plans, co-payments, and deductibles). We accept cash, personal checks, and VISA, MASTERCARD, AMEX OR DISCOVER for payments. A \$25.00 charge will be incurred for any returned checks.

In the event that you do not have medical insurance coverage, full payment will be expected at the time of service. We realize that temporary financial problems may affect the timely payment of your account. If this situation should occur, please contact our billing department immediately to assist you with the management of your account. **There will be an 18% interest charge for any balance 90 days past due from the date of service.**

If you are treated for a work related injury and the industrial carrier denies your claim, we will bill you and your individual insurance, provided we are given the correct billing information.

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 be here for your reserved time. 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.**

I hereby instruct and direct _____ insurance company to pay by check made out and mailed to:
B.E.S.T. Physical Therapy, Inc., 1601 S. De Anza Blvd., Suite 111, Cupertino, CA 95014

If my current policy prohibits direct payment to B.E.S.T. Physical Therapy, I hereby also instruct and direct my insurance carrier referenced above to make out the check to me and mail it as follows to **B.E.S.T. Physical Therapy, Inc., 1601 S. De Anza Blvd., Suite 111, Cupertino, CA 95014**, for professional or medical expense benefits allowable and otherwise payable to me under insurance policy as payment towards the total charges for the professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I also authorize the release of any information pertinent to my case to any insurance adjuster or attorney involved in this case.

A photocopy of this Assignment shall be considered as effective and valid as the original

I understand and agree to the above the financial policy. In addition, I authorize B.E.S.T. Physical Therapy, Inc. to initiate a complaint to the insurance Commissioner for any reason on my behalf.

Print Patient Name: _____ **SS#/ID#** _____

Signature of Patient/ Policyholder

Date

Witness

Signature of Claimant, if other than policyholder



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.

Email: bestphysicaltherapy@bestphysicaltherapy.com

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Cupertino, CA 95014

Phone: 408-257-2225 · Fax: 408-257-2485

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