



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, 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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