5145 Golden Foothill Parkway, #190 . Tel 916-941-2440 . Fax 916-941-2450

********* *PATIENT INFORMATION*

Last Name ____________________________________ First __________________________________ M.I. _______________

Male / Female DOB __________________ Age _______________ SS# ______________________ D.L. #_____________________

Address____ City/State/Zip ____

Home Phone #________________________ Cell Phone#_________________________ Email _______________________________

Employer______________________________ Work Phone #__________________________ Occupation_____________________________

Emergency Contact____________________________________ Phone# ____

Reason for Visit: ____

Is injury work related? ________________ Auto Related_______________ Other__________________ Date of Injury ________________

Referring Dr.___________________________ Dr. Phone # _______________ Dr. Fax #_______________

How did you hear about Beretta PT?____

INSURANCE / CASH / WORK COMP /AUTO Effective ___________ Verified by________________ Date_________

***Primary* Policy Holder**______________________ DOB________________ SS# ____________________ Relationship__________

Insurance Company Name _______________________________________ Phone number___________________________________

Insurance ID #______________________________ Group #___________________________ Claim # _______________________

Address _____________________________________ City ________________________ St_____________ Zip ________________

Adjuster_______________________________ Phone#____________________________ Fax#_______________________________

DOI _________________ Employer_____________________________________

Benefits: In / Out of Network Ded__________ Met________ Copay________ Out of Pocket________________________

Require RX: Y / N (MD/DO/DC) Visit Limit ___________ Any used _________ Combined w/ other therapy ___________________

Other:

INSURANCE / CASH / WORK COMP /AUTO Effective ___________ Verified by________________ Date_________

***Secondary* Policy Holder**____________________ DOB___________ SS# __________________ Relationship_________________

Insurance Company Name _______________________________________ Phone number___________________________________

Insurance ID #______________________________ Group #___________________________ Claim # _______________________

Address ____ City _________________ St________________ Zip ________________

Adjuster_______________________________ Phone#____________________________ Fax#_______________________________

DOI _________________ Employer_____________________________________

Benefits: In / Out of Network Ded__________ Met________ Copay________ Out of Pocket________________________

Require RX: Y / N (MD/DO/DC) Visit Limit ___________ Any used _________ Combined w/ other therapy ___________________

Other:

Attorney's Name__________________________ Phone#_________________________ Fax#________________________

Attorney's Address____ City/St/Zip ____

PATIENT MEDICAL HISTORY

Name________________________________ When did injury occur?__________________________________
Breifly Describe how the injury or accident occurred____
____
____
Are you currently taking any medications (prescription or non-prescription)? Yes No
Please list all____
____

Have you ever had any of the following services for this injury?

	Yes	No	When?
General Practitioner	____	____	________
Orthopedist	____	____	________
Neurologist	____	____	________
Physical Therapy	____	____	________
Chiropractic Care	____	____	________
Massage Therapy	____	____	________
Podiatrist	____	____	________

	Yes	No	When?
Emergency Room	____	____	________
X-Ray	____	____	________
CT Scan	____	____	________
MRI	____	____	________
EMG	____	____	________

Other:____
____

Do you have a history of any of the following?

	Yes	No	Details
High Blood Pressure	____	____	__________
Heart Problems	____	____	__________
Lung Problems	____	____	__________
Kidney Problems	____	____	__________
Stomach Problems	____	____	__________
Bowel/Bladder Problems	____	____	__________
Circulatory Problems	____	____	__________
Diabetes	____	____	__________
Cancer	____	____	__________
Multiple Sclerosis	____	____	__________
Parkinson's Disease	____	____	__________
Blood Disorders	____	____	__________
Stroke/Neurologic History	____	____	__________
Thyroid Problem	____	____	__________
Rheumatoid Arthritis	____	____	__________
Seizure Disorder	____	____	__________
Head Injury	____	____	__________

	Yes	No	Details
Allergies	____	____	__________
Broken Bones	____	____	__________
Headaches	____	____	__________
Weight Loss/Gain	____	____	__________
Numbness Tingling	____	____	__________
Vision Changes	____	____	__________
Hearing Changes	____	____	__________
Weakness	____	____	__________
Depression	____	____	__________
Pain at Night	____	____	__________
Hernia	____	____	__________
Pins/Metal Implants	____	____	__________
Osteoporosis	____	____	__________
Osteopenia	____	____	__________
Drink Alcohol?	____	____	__________
Do you smoke?	____	____	__________
Could be pregnant?	____	____	__________
Any Surgeries?	____	____	__________

Are you having difficulties:

	Yes	No
Dressing	____	____
Bathing	____	____
Reaching overhead	____	____
Lifting	____	____
Kneeling	____	____
Squatting	____	____
Up/Dn Stairs	____	____
Walking	____	____
Running	____	____
Sitting	____	____
Standing	____	____

Other________________________________

Any other information you feel is important?____________________
____

What are you goals for physical therapy______________________
____

I hereby assign all medical benefits to Beretta Physical Therapy. I understand that I am financially responsible for all charges. I hereby authorize release of all information necessary to secure payment. A photocopy shall be considered valid.

Patient Signature__________________________Date_______

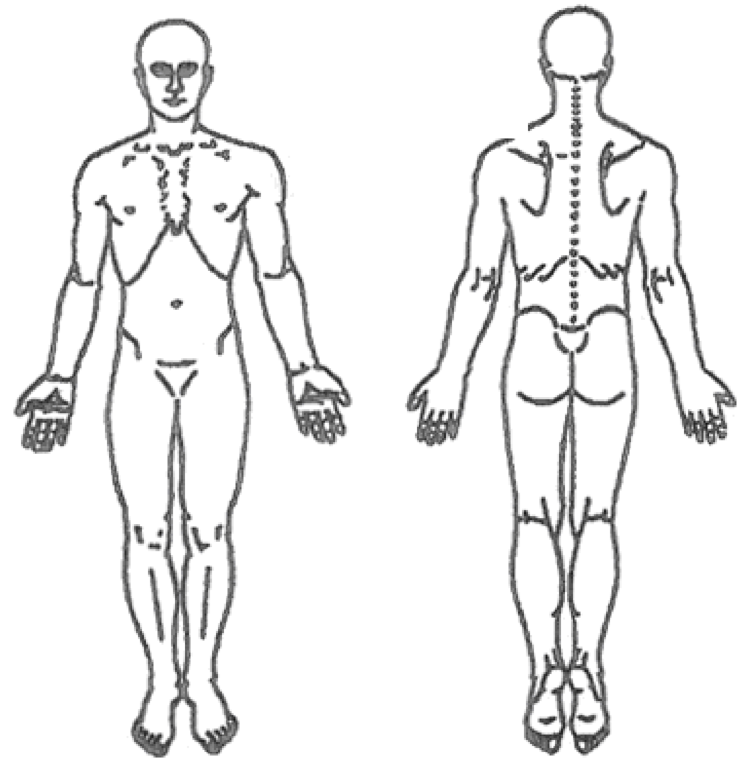
Pain and Symptom Status Report

Name: ____ Date: ____________________

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing

Ache	Burning	Numbness
MMM M	— — — — —	O O O O O O O

Pins and Needles	Stabbing	Other
□ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	/ / / / / / / / / / /	x x x x x x x



Chief Complaint and Visual Analog Scale

My Chief Complaint is: ____

Date First Symptom of your problem occurred on. ____________________

2nd Complaint ____

3rd Complaint: ____

Please circle on the scale below to indicate your CURRENT level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it

Please circle on the scale below to indicate your AVERAGE level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it

Please circle on the scale below to indicate your WORST level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it

Additional Comments ____

____

Financial Policy and Patient Responsibility

Beretta Physical Therapy is committed to providing our patients with the highest quality care. We thank you for taking the time to read and understand our policy. If you have any questions, please do not hesitate to discuss them with us.

It is the patients responsibility:

- To know their insurance policy. Patients should be aware of their benefit coverage including which healthcare providers are contracted with their plan, covered and non-covered benefits, authorization requirements, and cost share information such as deductibles, coinsurance, and co-payments. If you are not familiar with your plan coverage, we recommend you contact your carrier directly.
- To obtain a referral from their Primary Care Physician (PCP) and/or obtain authorization for treatment from their insurance carrier prior to receiving services. Any non-covered services are the financial responsibility of the patient.
- To pay their co-payment and/or deductible at the time of service.
- To pay any Medicare deductible and co-insurance amounts not covered by supplemental insurance.
- To promptly pay any patient responsibility indicated by their insurance carrier.
- To facilitate in Claims payment by contacting their insurance carrier when claims have not been paid.
- If med-pay applies (i.e. auto insurance or personal injury), it is their responsibility to know their limit, how much has been used and how much is available. Beretta Physical Therapy is unable to participate in any liens.

It is Beretta Physical Therapy's responsibility:

- To provide quality medical care.
- To file insurance claims as a courtesy to the patient. A 60 day period will be extended for pending insurance payment, after which the patient may be held responsible for the balance.

Attendance Policy: At Beretta PT, our patients spend an entire hour working one-on-one with a physical therapist (not an aide or an assistant). We find that this practice generally results in a decrease in the time needed to resolve your problem. Because of this, we ask that if you must cancel an appointment, call at least 24 hours in advance. **You will be charged $45 if you fail to do so, ______ (patient initials).**

Financial Policy Acknowledgement and Authorization to Evaluate and Treat

As a courtesy to you the insured, Beretta Physical Therapy will verify insurance benefits and coverage. This verification is only an estimation of insurance benefits at the time of verification and in no way a promise on behalf of the insurance company to pay for any services rendered. The patient, or legal guardian, is liable for all charges not covered by insurance, whether or not such coverage agrees with the estimated amount. The patient, or legal guardian, is also responsible for charges if the insurance carrier denies the claim or deems that the treatment provided is not medically necessary. As stated above, if med-pay applies, it is your responsibility to know your limit, how much has been used and how much is available.

I have read and understand the above financial policy. I understand that, regardless of my insurance claim status or absence of insurance coverage, I am ultimately responsible for the balance on my account for any services rendered.

I hereby authorize Beretta Physical Therapy to evaluate and treat my condition(s).

_______________________________________ _____/_____/_____

Patient or Responsible Party Signature Date

Release of Medical Information and Assignment of Benefits:

I authorize the release of medical information necessary for filing health insurance claims for me by Beretta Physical Therapy. I also authorize my insurance carrier(s) to make payment directly to Beretta Physical Therapy.

_______________________________________ _____/_____/_____

Patient or Responsible Party Signature Date

Beretta Physical Therapy's Notice of Information Practice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW CAREFULLY.

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

USES AND DISCLOSURES OF HEALTH INFORMATION

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

Beretta Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, or incidental disclosures. We also provide information when required by law.

In any other situation, Beretta Physical Therapy'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.

Beretta Physical Therapy's 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 of Information Practice 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 accurate 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. Beretta Physical Therapy 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 Beretta Physical Therapy may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of our personal information, please contact our practice manager at the address below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Beretta Physical Therapy's health information practices or if you have a complaint, please contact the following person:

Beretta Physical Therapy
5145 Golden Foothill Pkwy #190, El Dorado Hills, CA 95762
Telephone: 916-941-2440 Fax 916-941-2450

Signature constitutes acceptance of above policies

Patient's signature_________________________________ Date______________