

**BERETTA PHYSICAL THERAPY, Inc**

4822 Golden Foothill Parkway, Unit 9

El Dorado Hills, CA 95762

Tel 916-941-2440 . Fax 916-941-2450

\*\*\* Need Help Finding Us? Visit [www.berettapt.com/location](http://www.berettapt.com/location)

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**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ M.I.: \_\_\_\_\_

DOB \_\_\_\_\_ Age \_\_\_\_\_

Home Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone#: \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone# \_\_\_\_\_

**Reason for Visit:**

\_\_\_\_\_  
\_\_\_\_\_

Is injury work related? Y / N (circle) Auto Related Y / N (circle) Date of Injury: \_\_\_\_\_

Referring Dr.: \_\_\_\_\_ Dr. Phone #: \_\_\_\_\_ Dr. Fax#: \_\_\_\_\_

How will you be paying for services? Insurance Out of Pocket (Please Circle)

\*\*\*\*If using Insurance please bring all insurance cards to your first session.

How did you hear about Beretta PT?: \_\_\_\_\_

Other information you feel is important for us to know:

# PATIENT MEDICAL HISTORY

Name \_\_\_\_\_ When did injury occur? \_\_\_\_\_

Briefly 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?		Yes	No	When?
General Practitioner	_____	_____	_____	Emergency Room	_____	_____	_____
Orthopedist	_____	_____	_____	X-Ray	_____	_____	_____
Neurologist	_____	_____	_____	CT Scan	_____	_____	_____
Physical Therapy	_____	_____	_____	MRI	_____	_____	_____
Chiropractic Care	_____	_____	_____	EMG	_____	_____	_____
Massage Therapy	_____	_____	_____	Other: _____	_____	_____	_____
Podiatrist	_____	_____	_____				

Do you have a history of any of the following?

	Yes	No	Details		Yes	No	Details
High Blood Pressure	_____	_____	_____	Allergies	_____	_____	_____
Heart Problems	_____	_____	_____	Broken Bones	_____	_____	_____
Lung Problems	_____	_____	_____	Headaches	_____	_____	_____
Kidney Problems	_____	_____	_____	Weight Loss/Gain	_____	_____	_____
Stomach Problems	_____	_____	_____	Numbness Tingling	_____	_____	_____
Bowel/Bladder Problems	_____	_____	_____	Vision Changes	_____	_____	_____
Circulatory Problems	_____	_____	_____	Hearing Changes	_____	_____	_____
Diabetes	_____	_____	_____	Weakness	_____	_____	_____
Cancer	_____	_____	_____	Depression	_____	_____	_____
Multiple Sclerosis	_____	_____	_____	Pain at Night	_____	_____	_____
Parkinson's Disease	_____	_____	_____	Hernia	_____	_____	_____
Blood Disorders	_____	_____	_____	Pins/Metal Implants	_____	_____	_____
Stroke/Neurologic History	_____	_____	_____	Osteoporosis	_____	_____	_____
Thyroid Problem	_____	_____	_____	Osteopenia	_____	_____	_____
Rheumatoid Arthritis	_____	_____	_____	Drink Alcohol?	_____	_____	_____
Seizure Disorder	_____	_____	_____	Do you smoke?	_____	_____	_____
Head Injury	_____	_____	_____	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.

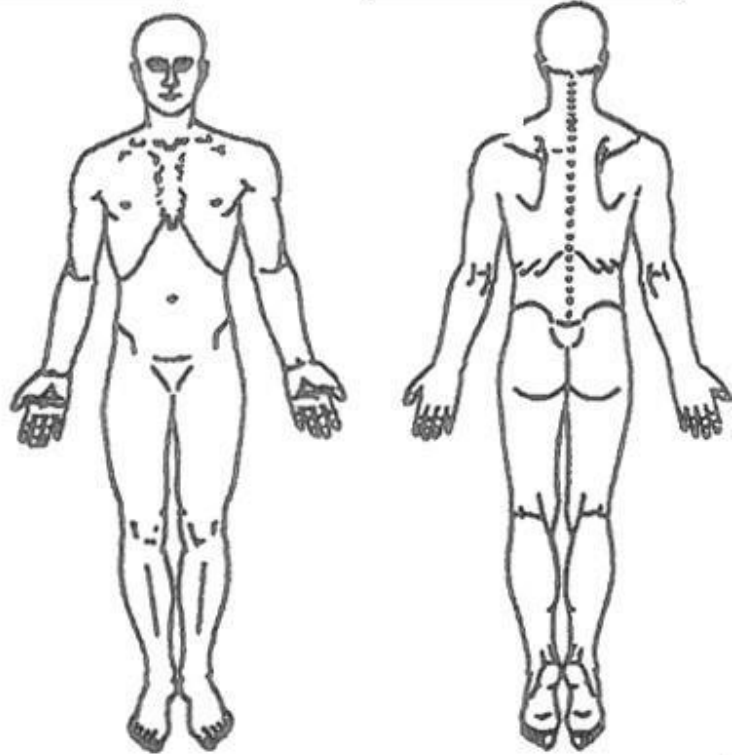
**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

# 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**  
MMM  
M

**Burning**  
\_\_\_\_\_  
\_\_\_\_

**Numbness**  
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**

4822 Golden Foothill Pkwy #9 El Dorado Hills, CA 95762

Telephone: 916-941-2440 Fax 916-941-2450

Signature constitutes acceptance of above policies

**Patient's signature**

**Date**