5145 Golden Foothill Parkway, #190
El Dorado Hills, CA 95762
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 _____

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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 Physical	☐	☐	_____	CT Scan	☐	☐	_____
Therapy Chiropractic	☐	☐	_____	MRI	☐	☐	_____
Care Massage	☐	☐	_____	EMG	☐	☐	_____
Therapy Podiatrist	☐	☐	_____	Other:_____			
	☐	☐	_____	_____			

Do you have a history of any of the following?

	Yes	No	Details		Yes	No	Details
High Blood Pressure	☐	☐	_____	Allergies	☐	☐	_____
Heart Problems Lung	☐	☐	_____	Broken Bones	☐	☐	_____
Problems Kidney	☐	☐	_____	Headaches	☐	☐	_____
Problems Stomach	☐	☐	_____	Weight Loss/Gain	☐	☐	_____
Problems	☐	☐	_____	Numbness Tingling	☐	☐	_____
Bowel/Bladder Problems	☐	☐	_____	Vision Changes	☐	☐	_____
Circulatory Problems	☐	☐	_____	Hearing Changes	☐	☐	_____
Diabetes	☐	☐	_____	Weakness	☐	☐	_____
Cancer	☐	☐	_____	Depression	☐	☐	_____
Multiple Sclerosis	☐	☐	_____	Pain at Night	☐	☐	_____
Parkinson's Disease Blood	☐	☐	_____	Hernia	☐	☐	_____
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/Down 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_____

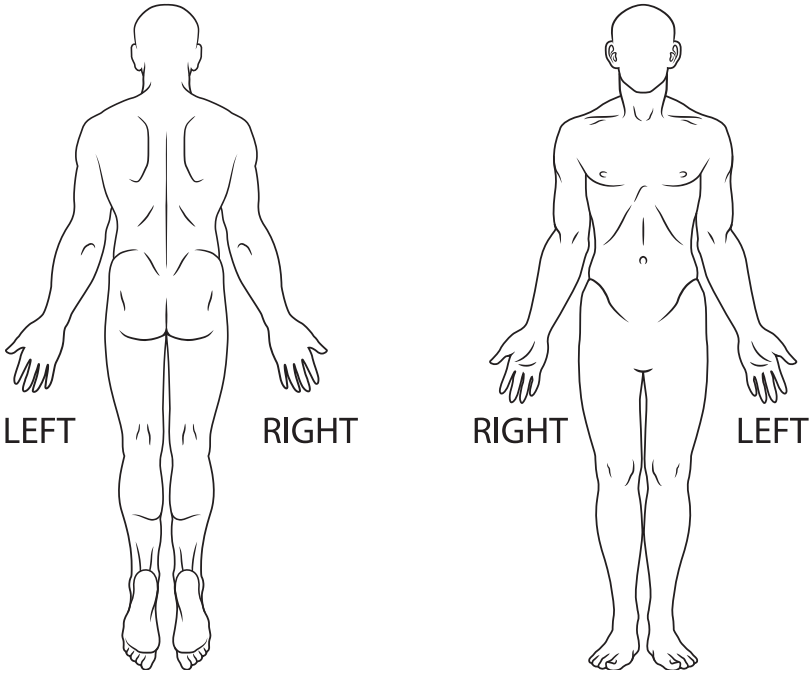
Pain and Symptom Status Report

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	— — —	0 0 0 0
M	— —	0 0 0

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 <u>CURRENT</u> level of pain:												
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**
Please circle on the scale below to indicate your <u>LOWEST</u> level of pain:												
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**
Please circle on the scale below to indicate your <u>HIGEST</u> level of pain:												
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**

Additional Comments: _____

_____

What goals do you wish to achieve in physical therapy? _____

_____

_____

_____

_____

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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).

_____ _____/_____/_____ Date

Patient or Responsible Party Signature

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.

_____ _____/_____/_____ Date

Patient or Responsible Party Signature

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_____