

**BRADY PHYSICAL THERAPY
PATIENT INFORMATION AND BRIEF HISTORY**

Name _____ Home PH# _____ Cell #/Pager _____

Address _____ City _____ State _____ Zip _____

SSN or Drivers license _____ DOB _____ M ___ F ___ Married ___ Single ___ Other ___

Employer _____ City _____ Zip _____ PH# _____

Spouse (Parent, if minor) _____ DOB _____ Day PH# _____

Primary Physician _____ Referring Physician _____

Problem Area _____ Does this relate to an accident? Yes / No - At Work ___ Other ___

Date of injury/onset/surgery? _____ Are you currently working? Yes / No

Time of injury, address where it took place, how it happened: _____

Do you have an attorney for this injury? Yes / No Name _____

Address _____ PH# _____ FAX# _____

Brief History - Do you have or have you had any of the following:

Diabetes _____	Kidney Problems _____	Previous Surgery _____
High blood pressure _____	Nervous disorders _____	Hernia (Ventral, _____
Heart Disease _____	Pregnancy _____	Inguinal, etc.) _____
Pacemaker _____	Allergies heat/ice _____	Seizures _____
Heart Attack _____	Other Allergies _____	Metal or other _____
Headaches _____	Dermatitis _____	Implant _____

If yes, please give dates, details, and family history: _____

Are you presently taking medications? _____ If yes, please list what medications and for what condition: _____

How did you hear about Brady Physical Therapy? _____

The above information is correct to the best of my knowledge. I agree that Brady Physical Therapy may furnish the insurance company, the financially responsible entity or the referral doctor, or any other person I authorize in writing, information concerning said physical therapy services. I hereby assign payment to Brady Physical Therapy of medical benefits, if any, otherwise payable to me, for physical therapy services. I understand I am financially responsible for changes not covered by this assignment.

Date

Signature of insured person (or parent if minor)

BRADY PHYSICAL THERAPY
Payment Policy Regarding Cash Patients

1. Payment for services and supplies are due at time of service.
2. You may pay by Cash, Check, Visa, Mastercard, Discover, or American Express.
3. All charges over 60 days are to be paid in full by the patient.
4. **Please give 24 hours notice of cancellation. The fee for missed appointments is \$50.00. The fee for late cancellations is \$25.00.**
5. Rebilling charges of 1 1/2% per month will be added to unpaid balances over 60 days.
6. Special billing requests are subject to additional charge.
7. Returned checks are subject to a \$10.00 service charge.

Thank you for choosing BRADY PHYSICAL THERAPY for your physical therapy needs. We are committed to providing you with the best possible care and attention. If at any time you have a question regarding your treatment or account, please let us know so we may answer your questions promptly.

The staff of Brady Physical Therapy

Date: _____ Signature: _____

BRADY PHYSICAL THERAPY

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.

BRADY PHYSICAL THERAPY'S LEGAL DUTY

BRADY PHYSICAL THERAPY 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 OF HEALTH INFORMATION

BRADY PHYSICAL THERAPY uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, BRADY PHYSICAL THERAPY 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.

BRADY PHYSICAL THERAPY may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, BRADY 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.

BRADY PHYSICAL THERAPY 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

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 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 health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. BRADY PHYSICAL THERAPY will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

PATIENT INFORMATION CONSENT FORM

I have read and fully understand BRADY PHYSICAL THERAPY's Notice of Information Practice. I understand that BRADY PHYSICAL THERAPY may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand the BRADY PHYSICAL THERAPY will consider requests for restriction in a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for the purposes as noted on BRADY PHYSICAL THERAPY's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name

Signature

Date

DESIGNATED INDIVIDUALS AUTHORIZATION

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. Examples: Doctors, insurance, attorney, and/or family members.

Authorized Designees:

Name: _____

Relationship _____

Name: _____

Relationship _____

Name: _____

Relationship _____

Name: _____

Relationship _____

Patient Name

Signature

Date

Daniel T. Brady, M.A.
Registered Physical Therapist
Certified Athletic Trainer

BRADY

PHYSICAL THERAPY

Brady Physical Therapy
2001 Winward Way, #101
San Mateo, Ca 94404

PATIENT QUESTIONNAIRE

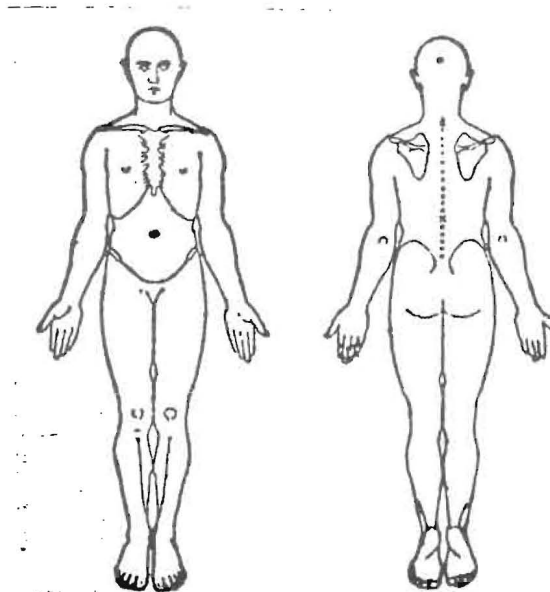
DATE: _____

NAME: _____

DIAGNOSIS: _____

PLEASE DESCRIBE HOW THIS PROBLEM FIRST BEGAN: _____

PLEASE MARK AREA OF PAIN
OR PROBLEM ON CHART



DESCRIBE PAIN OR PROBLEM: _____

ON A SCALE OF 1-10, 1 BEING NO PAIN, 10 BEING THE WORST PAIN YOU
HAVE FELT FROM THIS PROBLEM, HOW IS YOUR PAIN? RATE EACH AREA
SEPARATELY? _____

DO YOU HAVE ANY QUESTIONS FOR THE THERAPISTS? _____
