

**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, BILLING & CANCELLATION POLICY**

**PAYMENT & BILLING POLICY**

- ALL per visit copayments are due at the time of service.
- Percentage co-insurance will be billed to you monthly as we receive insurance payments.
- Supplies and Athletic Taping are payable upon receipt.
- Returned check fee is based on bank fees and proof of fee will be provided.
- We will bill your insurance weekly and you will receive a statement of patient portion due monthly.
- Your insurance can not guarantee payment until charges have been billed, therefore you are responsible for services your insurance does not pay for.
- Medicare patients – Brady Physical Therapy is certified with Medicare and requires that we bill them directly. We do not have a contract with Medi-Cal. This means that if you have Medi-Cal as your secondary, they will not pay us and you will be financially responsible for the Medicare deductible and co-insurance of 20%. Medicare has a \$2010 maximum benefit for physical and speech therapies combined for the year 2018. This means Medicare will allow \$2010 for the therapies combined. After your \$183.00 deductible has been met, they will pay 80% (\$1461.60) and you or your secondary will pay the remaining 20% (\$365.40). We will do our best to keep track of your charges so they do not exceed the cap. If you had physical or speech therapies prior to receiving treatment here, please advise the receptionist.
- Auto Insurance patients – We will bill your auto insurance if you have medical coverage. If not, it may be possible to bill your private health insurance. We do not bill third party insurance.
- Workers' Compensation patients – We bill your Workers' Compensation insurance directly. All visits must be authorized by the insurance before treatment can begin. We will work with your doctor and the insurance to obtain authorization in a timely manner to avoid delays in your recovery. Please note: It is important to keep with your set appointments and a consistent schedule for a faster recovery. Two (2) or more missed appointment or late cancellations will force our office to notify your workers' compensation insurance company.

**CANCELLATION / NO SHOW POLICY**

- Please give **24 HOUR NOTICE** if you can not make your appointment. There will be a charge of **\$25.00 for Late Cancellation and \$50.00 for a Missed Appointment.**
- *Thank you for choosing Brady Physical Therapy. If you have any questions, please do not hesitate to ask one of our staff members and we will do our best to serve you.*

Print Name \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_ Name of Your Insurance \_\_\_\_\_

# Notice of Privacy Practices for Brady Physical Therapy

*Updated 2/2012*

**This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.**

Brady Physical Therapy respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so. The law protects the privacy of the health information we create and obtain in providing our care and services to you. Federal and state law allows us to use and disclose your protected health information for purposes of treatment, payment, and health care operations.

Examples of uses and disclosures of protected health information for treatment, payment, and health care operations include:

**For treatment, for payment, for health care operations.**

**Your Health Information Rights:** The health and billing records we create and store are the property of Brady Physical Therapy. The protected health information in it, however, generally belongs to you. You have a right to: Receive, read, and ask questions about this Notice. Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request, but we will comply with any request granted. You may request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request. It will be stored in your medical record, and included with any release of your records. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months. Please sign, date, and give us all your requests in writing

**Our Responsibilities - We are required to:**

Keep your protected health information private. Give you this Notice. Follow the terms of this Notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our office/medical records department to pick one up.

**To ask for help**

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact: Annie Singler, Administrator 650-571-6800.

**Notification of family and others**

With your consent we may release health information about you to a friend or family member who is involved in your medical care.

We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital. In addition, we may disclose health information about you to assist in disaster relief efforts. You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it.

**Some of the ways that we may use and disclose your protected health information without your authorization are as follows:**

To comply with workers' compensation laws—if you make a workers' compensation claim and for public health and safety purposes as allowed or required by law. -To report suspected abuse or neglect to public authorities. -For law enforcement purposes such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime. -For health and safety oversight activities. -For work-related conditions that could affect employee health -To the military authorities of U.S. and foreign military personnel. -In the course of judicial/administrative proceedings at your request, or as directed by a subpoena or court order.

**Other uses and disclosures of protected health information:** Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

Acknowledgement of Receipt of Notice of Privacy Practices

Brady Physical Therapy reserves the right to modify the privacy practices outlines in this notice.

I have received and read the "Notice of Privacy Practices for Brady Physical Therapy.

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**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: \_\_\_\_\_

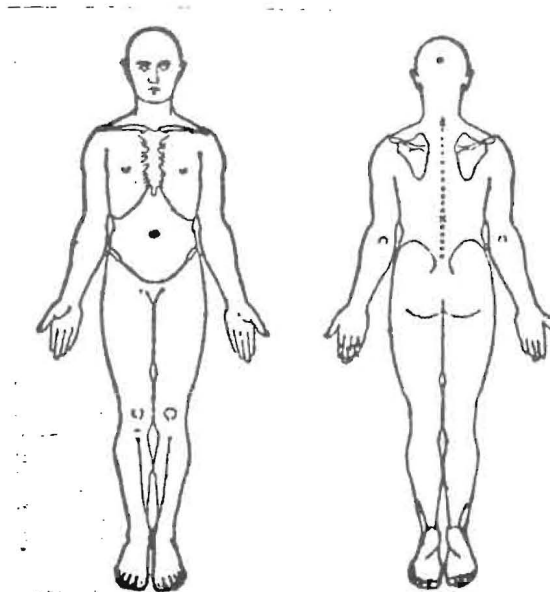
NAME: \_\_\_\_\_

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? \_\_\_\_\_

\_\_\_\_\_