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 time of service.
- Percentage co-insurance will be billed to you as we receive insurance payments.
- SUPPLIES are not normally covered by insurance therefore are payable upon receipt.
- Returned check fee is $15.00
- We will bill your insurance weekly for services and you will receive a statement of charges and payments every month if there is a patient portion due at that time.
- Your insurance cannot guarantee payment until charges have been billed, therefore you are responsible for what your insurance does not pay.
- Auto 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 3rd party insurance.
- Worker's Compensation patients – We will bill your Worker's Compensation insurance directly. All visits must be authorized by the worker's compensation insurance before you can receive treatment. 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 appointments or late cancellations will force our office to notify your worker's compensation insurance company.
- 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 patients – Medicare has a $1,880.00 cap for physical and speech therapies combined for the year 2012. This means Medicare will allow $1,880.00 for the therapies combined. They pay 80% ($1,504.00) and you or your secondary will pay the 20% (376.00). 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.

CANCELLATION / NO SHOW POLICY

- Please give a **24 HOUR NOTICE** if you cannot make your appointment. We have fees for late cancellations and missed appointments: **Late Cancel - $25.00 & Missed Appointments - $50.00**

Thank you for choosing Brady Physical Therapy. If you have any questions along the way, 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, f**or 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: _____

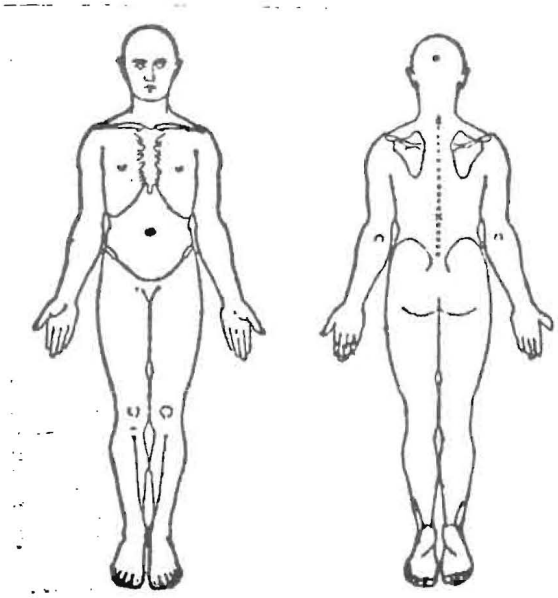
DIAGNOSIS: _____

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? _____

_____

_____