

**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
2001 Winward Way, #101
San Mateo, Ca 94404

WORK TASK QUESTIONNAIRE

DATE: _____

NAME: _____

OCCUPATION/JOB TITLE: _____

Briefly describe your job duties: _____

1. Check the frequency and number of hours a day that you are required to do the following specific types of activities in your job:

ACTIVITY	CONTINUOUS	INTERMITTENT	NUMBER OF HOURS A DAY							
			1	2	3	4	5	6	7	8
a. Sitting										
b. Standing										
c. Squatting										
d. Bending										
e. Climbing										
f. Kneeling										
g. Twisting										
h. Pushing/Pulling										
i. Lifting: <input type="checkbox"/> over head, <input type="checkbox"/> from floor										
l. Fine Hand Manipulation										
m. Typing/ Data Entry										
n. Phoning										
o. Filing										
p. Other:										

2. Check the maximum amount of weight you lift in your job
 0-10 lb. 10-20 lb. 20-50 lb. 50-75 lb. 75-100 lb. over 100 lb.
 a. How many times a day are you required to lift the above weight? _____

3. Work Status: Full Work Duty Modified Work with limitations Unable to Work
 a. If you checked the Modified Work with Limitations, briefly describe your limitations on the lines below

4. Are you working a full day at this time? YES NO
 a. If your answer was NO above, how many hour are you working per day at this time? _____

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

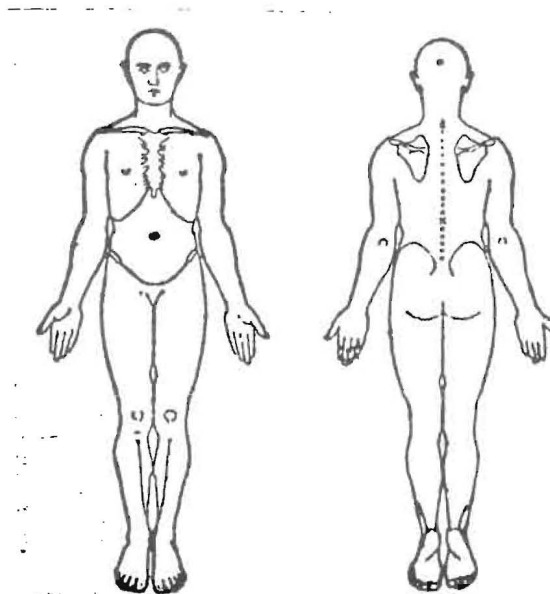
DATE: _____

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? _____
