Patient's Name: ___________________________ Date:____________________

BREAKINGTHROUGH SAN DIEGO PHYSICAL THERAPY

Patient Intake Form

Name:____ Initials and Date of call:______________

Appt date: _________________ Time:______________ Therapist:_______________________________

Who referred you to us?:____

Was this the first time you heard of us? Y N If no, where?__________________________________

Discipline requested: Physical Therapy

Patient Information:

Patient Name:__________________________________ DOB____________SSN____________________

Home Phone:________________ Work Phone:___________________ Cell Phone:_______________

Address:____

Email address: _____________________________Best time and way to reach you_______________

Sex: M F Marital Status: Single Widowed Married Separated Divorced Minor

Patient Employer/school:___________________________Address:_____________________________

Emergency Contact:

Name: _______________________________________Relationship: ______________________________

Home Phone:________________ Work Phone:___________________ Cell Phone:_______________

Referring Physician:

Name: _______________________________________Address: ________________________________

Phone: ______________________ Fax: ____________________ Email: __________________________

Primary Care Physician:

Name: _______________________________________Address: ________________________________

Phone: ______________________ Fax: ____________________ Email: __________________________

Accident Information:

Is this injury due to an accident: Y N Type of injury: Home Work Auto Other Date of injury: ____________ Have you made a report of your accident?: Y N

Attorney name: ____________________________________Phone: ____________________________

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BREAKINGTHROUGH SAN DIEGO PHYSICAL THERAPY

Patient's Name: ___________________________ Date:____________________

Insurance Verification Form

Patient's Primary Insurance:

Primary Insurance: ____ Phone: ___________________

Patient's name: ____

Policy Holder Information:

Name: ____________________________ Relationship:_________________________ DOB:__________

Employer:____ SSN:______________________________

Policy ID Number: __________________________________ Group Number: _____________________

Policy Information:

Covered Amount: _____ / _____% Co-pay: $_____ Deduct: $_________ Deduct met? ________

Referral req? ______ Pre-auth/Pre-cert req? ______ Effective date of policy: ________________

Pre-auth/pre-cert phone: _____________________ Pre-auth/pre-cert fax: _____________________

Max # visits: _____ # of visits used: _________ Has pt had home health? Y N Dates: ___________

Any policy exclusions/restrictions? ____

Insurance Contact: _____________________ Contacted by: ___________________ Date: _________

Mail claims to: ____

Notes: ____

I HAVE READ THE INSURANCE VERIFICATION AND I UNDERSTAND THESE BENEFITS ARE NOT GUARANTEED. THE ABOVE IS AN ESTIMATE FROM MY INSURANCE COMPANY. MY CO-PAYMENTS AND % OF RESPONSIBILITY IS DUE AT THE TIME I AM TREATED. IF I OWE MORE THAN THE INSURANCE COMPANY ORIGINALLY QUOTED, I WILL BE RESPONSIBLE FOR THAT AMOUNT. IF I OVER-PAY MY BILL, I WILL BE REIMBURSED THE AMOUNT I OVERPAID ONCE I AM DISCHARGED. I HAVE RECEIVED A COPY OF THIS VERIFICATION FORM.

Patient Signature: ____ Date: _____________________

Practice Representative: _____________________________________ Date:_____________________

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Patient's Name: ___________________________ Date:____________________

BREAKINGTHROUGH SAN DIEGO PHYSICAL THERAPY

Patient Condition Form

Reason for visit: _________________________ what did you hurt? ___________________________

How did you get hurt? ____

____

When did your symptoms start? When did the injury happen? _______________________________

Did you get surgery? If so, when ?__________ Date to f/u with a doctor? _____________________

What is the name or kind of surgery? ____________ Is this condition getting worse? Y N

Rate severity of pain on a scale of 0 (no pain) - 10 (severe pain): ___________________________

Type of pain: • Sharp • Dull • Throbbing • Numbness • Cramps • Aching • Tingling • Shooting • Burning •Stiffness • Swelling • Other_______________________________

How often do you have this pain?: ____

Is it constant or intermittent? ____

Does it interfere with your: • Work • Sleep • Daily Routine • Recreational activities

Activities or movements that are painful to perform: • Sitting • Standing • Walking • Bending • Lying down Other: ____

Prior to the condition or injury, please rate your functional status with self-care and home management activities: • Excellent • Good • Fair • Poor

Please rate your current functional status with self-care and home management activities: • Excellent • Good • Fair • Poor

Have you experienced any of the following?: • Changes in bowel/bladder • Non-healing sores/wounds • Fatigue

• Unexplained weight loss • Referred or radiating pain • Fever/sweats

• Pain worse at rest vs activity • Unexplained lower or upper extremity weakness

Are you currently pregnant? Y N IF yes, what is your due date? ___________________________

Family/Social History:

Do you live alone? Y N If no, with whom do you live? _____________________________________

What type of home • 1 story • 2 story • Apartment • Tri-level • Other: ___________

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BREAKINGTHROUGH SAN DIEGO PHYSICAL THERAPY

Patient's Name: ___________________________ Date:____________________

Are there stairs in the home or to get into the home? Y N If yes, how many? ___________________

Are you currently working? Y N What is your occupation? _______________________________

Do you smoke? Y N If yes, packs/day: ___ Do you drink alcohol? Y N If yes, drinks/week ___

Do you exercise? Y N If yes, how many times per week? _____

List 3 goals you want to achieve out of physical therapy: 1.____
2. ____ 3.____

Health History Form

Have you received any of the following treatment(s) for your condition/injury?:

• Medication • Surgery • Physical Therapy • Chiropractic • Other: ______________________

If yes to above, please describe: ____

Name and address of other doctors who have treated you for your condition: _______________

____

Have you had any diagnostic testing: • X-ray •MRI • CT Scan • Bone Scan • Other _________ If you have had testing, please provide dates: ____

Have you been diagnosed with any of the following conditions?

	Yes	No		Yes	No
Osteoporosis			Have a Pacemaker		
Cancer			Hearing or Visual Impairment		
Diabetes			Thyroid Problem		
Arthritis			Kidney Disease		
High Blood Pressure			Vertigo		
Circulatory Problems			History of Falls		
Depression			High Cholesterol		
Seizures			Contagious Disease		
Heart Problems			Stroke		

Please list any other injuries or diagnoses not listed above: _________________________________

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Patient's Name: ___________________________ Date:____________________

Please list all past injuries and/or surgeries you have had with dates: ________________________

____

Are you currently taking over-the-counter medication, vitamins or supplements? Y N If yes, please list:

____

Are you currently taking prescribed medication? Y N If yes, please list: ____________________

____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize BreakingThrough San Diego Physical Therapy to obtain my Protected Health Information including, but not limited to, History and physical exam, lab reports, progress notes, X-Ray reports, substance abuse (including alcohol/drug abuse), Mental Health (including psychotherapy notes), HIV related information (including AIDS related testing).

I understand that this authorization will expire 365 days from the date I have signed this form and that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified, except to the extent action has already been taken in reliance upon it. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.

PRIVACY NOTICE

By my signature below, I acknowledge that I have received a copy of this practice's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law and understand my rights as a patient regarding my personal health information.

TREATMENT COMMITMENT

BreakingThrough San Diego Physical Therapy cares very much about each person we treat. We are committing to you, our patient, to deliver Exceptional Care, with Exceptional Results! We request of you, our patient, a commitment to help us deliver what we promise, by understanding what is required of you. You play a large role in your health by the actions you choose to take. Listed are some of your responsibilities as a patient at BreakingThrough San Diego Physical Therapy:

1. Attending, on time, all scheduled appointments.
2. Informing your therapist of your progress, each visit.
3. Compliance with your treatment plan developed by your therapist.
4. Asking questions when you do not understand any instructions given to you by our staff.
5. Notifying your therapist in advance of your next doctor's appointment.

PATIENT MISSED APPOINTMENT POLICY

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Patient’s Name: ___________________________ Date:____________________

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well-being and gain of your abilities is something everyone in our clinic takes quite seriously. Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore, we have certain rules that need to be followed in order to ensure the most optimum results.

In an instance of cancellation, without 24 hours-notice, we reserve the right to charge you a $50.00 fee. In an instance of a no-show you will be charged a $50.00 fee. After the second no-show or third cancelled appointment all future appointments will be removed from the schedule and you will be added to our “same day appointment only” list.

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order. We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

By signing, Patient agrees & understands all items outlined above

____ _________________

Signature of Patient Date

____ _________________

Practice Representative Date

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Patient's Name: ___________________________ Date:____________________

BREAKINGTHROUGH SAN DIEGO PHYSICAL THERAPY

Financial Policy

We are committed to providing you with the best in Therapy care. In order to do this without compromising our patients, this policy has been implemented for each patient. If you have medical insurance, we are happy to assist you in receiving your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

・Payment for services is due at the time services are rendered unless other acceptable and agreed upon arrangements have been approved in advance by our staff. We accept cash, checks, Visa, MasterCard and Discover. We will be accommodating to you in the process of seeking reimbursement from your Insurance carrier. In special instances, we may accept assignment of insurance benefits.

・Deductibles and Copayments must be made at each visit. It is our policy to collect a percentage of each visit or the entire fee until a deductible has been reached.

・Please be further advised that Returned checks and balances older than 30 days from your Treatment discharge may be subject to additional collection and legal fees, as well as, interest charges of 1.6% per month.

・If you participate with our in-network groups such as MEDICARE, BCBS, MAMSI, AETNA, UHC, CIGNA and Johns Hopkins Healthcare Group, we will bill your insurance company and accept assignment of benefits. You will be responsible for any copays or deductibles at each visit. We will verify your coverage and determine your out-of pocket cost prior to treatment starting. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

Please be aware of the following:

1. Your insurance is a contract between you, your employer and the insurance company.

2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier.

3. Not all services and diagnosis codes are a covered benefit in all insurance contracts.

4. We will not COMPRISE patient care based on an insurance company's "FEE SCHEDULE".

5. Verification of your insurance benefits is not a guarantee that payment will be made.

In cases involving Auto Claims and Workers Compensation, we will ONLY accept payment directly from the patient or from their insurance company and will arrange to accept payments from attorneys on a case by case basis. If a patient has instructed their insurance company to send payment to their attorney, the patient will be billed and held solely responsible and accountable for their bill. We will accept settlements on auto

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accounts only after prior approval and a letter of protection is on file. We must emphasize that as a Medical provider, our relationship is with you, not your insurance company.

While the filing of an insurance claim is a courtesy that we extend to our patients, all charges are your responsibility from the date the services were rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above policy or any uncertainty regarding your insurance coverage, **PLEASE don't hesitate to ask us. WE ARE HERE TO HELP YOU!**

____ _________________

Signature of Patient Date

____ _________________

Practice Representative Date

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ASSIGNMENT OF MEDICAL BENEFITS, PAYMENT RESPONSIBILITY AND AUTHORIZATION FOR TREATMENT

PATIENT: ____

1. THE UNDERSIGNED, hereby authorize BreakingThrough San Diego Physical Therapy and its affiliates (“Provider”) to render to Patient physical therapy, occupational therapy, speech therapy or other related services (collectively, “Therapy Services”) that Provider or Patient’s treating physician determines may be necessary or advisable. Patient agrees to cooperate with all reasonable requests by Provider in connection with Provider’s rendition of Therapy Services.

2. THE UNDERSIGNED, hereby certify that all information provided to Provider by the undersigned or Patient, including any information in connection with applying for a payment under Title XVIII of the Social Security Act, is true and accurate in all respects.

3. THE UNDERSIGNED, hereby authorize Provider to disclose any information, furnished to Provider or obtained by provider in connection with Patient’s treatment (including information concerning a related Medicare claim), to any physician, governmental agency (including the Social Security Administration or any of its intermediaries or carriers), insurance company or health care facility requesting such information.

4. THE UNDERSIGNED, hereby assign to Provider all Medicare benefits and Medicaid benefits to which Patient may be entitled for any Therapy Services rendered by Provider. The undersigned hereby authorize and direct Provider to apply and file for all such benefits on behalf of Patient. In the event Patient is covered by both Medicare and Medicaid, Patient’s Medicare deductible and any applicable Medicare co-payment will be covered by Medicaid. The undersigned acknowledge that Provider has disclosed to the undersigned that Provider is a supplemental Medicaid provider and that Provider is paid directly by Medicaid. In addition, the undersigned approves contact with the appropriate family members for medical claims management purposes.

5. THE UNDERSIGNED, hereby assigned to Provider all private medical insurance benefits (primary and secondary, including med. Gap providers) or other benefits to which Patient may be entitled for any Therapy Services rendered by Provider. The undersigned hereby authorize and direct provider to apply and file for all such benefits on behalf of Patient.

6. THE UNDERSIGNED, authorizes BreakingThrough San Diego Physical Therapy to deposit checks received on a Patient’s account when made out to the patient or signed over by the patient when the Insurance Company pays against services provided.

7. THE UNDERSIGNED, agree that the undersigned shall be jointly and severally financially responsible for any portion of Provider’s invoice that is not paid, except in the event of Medicare denial or Medicaid eligible

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recipients. The undersigned warrant and represent to Provider that Patient is not a member of, or covered by, a health maintenance organization or similar arrangement. The undersigned shall be liable to Provider for all services rendered by Provider in the event Patient is covered by a health maintenance organization or similar arrangement.

8. THE UNDERSIGNED and patient agree to execute any documents and perform any acts that the Provider may reasonably request. The undersigned warrant and represent that attached hereto are originals or certified copies of any applicable powers of attorney, health care surrogate forms or court orders appointing the undersigned as the legal guardian of Patient.

9. THE UNDERSIGNED, agree that the provisions hereof shall continue in full force and effect until Provider has received written notice of termination signed by the undersigned; provided, however, that the provision of paragraphs 2, 4, 5, and 6 shall survive any such termination.

10. THE UNDERSIGNED, acknowledge that Provider has disclosed to the undersigned that no physician owns any interest to Provider.

11. THE UNDERSIGNED understands that they have a choice or rehabilitation service providers.

____ _________________

Patient's Signature/Legal Representative Date

____ _________________

Practice Representative Date

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patientprivacyrights

Health Privacy Rights

Health Privacy "Rights" Under HIPAA

- Receive **notice** of how providers **use and share** your information with over 4 million "covered entities", **without asking you** ("Privacy Notice" or "Notice of Privacy Policies").
- The right to a copy of your health records. The provider may charge a "reasonable fee" for such copies.
- You can **request changes** to your health records. The provider does NOT have to make the changes requested. Your changes must be added to your records and the provider has to state reasons s/he disagrees with changes.
- You can **request an accounting of disclosures** of your health information. Most disclosures do not require consent and have no audit trails. Audit trails are required only for disclosures for "non-routine" uses.
- Health establishments and "covered entities" are required to **secure information** to the best of their ability, and a **privacy official** must be designated by each "covered entity."
- The ADA prohibits an employer from asking about health information or requiring a physical prior to an offer if they have more than 15 employees. After the offer is made, the employer may require a medical exam if it is required by all employees with similar positions. Employers may also ask employees to authorize disclosure of their medical records. **But, if the employer is self-insured they can access their employees' medical information without consent.**

  Job discrimination is the most common complaint sent in to Patient Privacy Rights.

These rights are based on thousands of years of medical ethics, our own Constitution and state laws. None of these rights are provided by HIPAA.

Health Privacy Rights You Should Have

- Right to **control** who can see, use, share and sell your health information.
- Right to **feel safe talking truthfully** to your doctors.
- Right to privacy and control of health information unless otherwise stated or required by law.
- Right to be **notified of any breach** or possible breach of information.
- Right to **audit trails** of every disclosure of health information. Health IT makes it easier than ever to know exactly who has your information.
- Right to EHR and PHR systems that have the highest standards for **security (keep hackers out).**
- Right to participate in **research** and have researchers access your records ONLY if you give informed consent
- Right to **segment sensitive information** such as mental health, addiction or STDs, in your health record.
- Right to obtain **prescriptions** with privacy; no one should be able to use or sell your prescriptions without your consent.
- Right to obtain **employment, insurance, credit, admission to schools**, etc. without being compelled to share health information unless required by statute.

Patient Privacy Rights is working to ensure **these rights** are guaranteed by Congress.

Our Contact Information:
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F: 760-696-3368
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