BURLINGAME THERAPEUTIC ASSOCIATES, II

BURLINGAME THERAPEUTIC ASSOCIATES, II

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name:			
Date of Birth:	Age:	Sex: M / F	Social Security #:
Address:			Home Phone:
City:	State:	Zip:	Mobile Phone:
Employer:	Occupation:		Work Phone:
Patient Email:			
Emergency Contact:	Relationship:		Emergency Contact #:
Referring Physician:		Diagnosis:	

Fill Below if: Auto Accident/ Worker Comp / Sports Injury

Date of Injury/Illness:	Type of Accident (Auto, Worker Comp, Etc.):	
Insurance Company Name:	Phone Number:	
Claim #:	Adjusters Name:	Adjusters Phone:

Consent/ Assignment / Release of Information

I consent to any treatment rendered to the patient under the treatment plan devised by my treating physical therapist. I hereby accept responsibility for all charges pertaining to treatment or services performed. I understand that I am financially responsible to the clinic for all charges incurred. I hereby assign any insurance benefits due me to the clinic and authorize the release of any information necessary for payment of charges incurred.

Medicare Regulations (if applicable): If you were covered under home health, please tell us your discharge date _____. Medicare requires that each patient have short and long term goals established. Continued coverage is dependent upon successfully achieving short term goals. When there are no achievable goals, Medicare classifies physical therapy as "maintenance" and does not consider the care to be covered. There must be monthly review of the treatment program by the physician. Medicare will no pay for physical therapy services over $1,980 (24 visits) for dates of services between January 1- December 31, 2019 (when provided outside a hospital outpatient clinic).

Cancellation and No Show Policy

You will be responsible for a $50.00 fee, if you no show or cancel an appointment with less than a 24 hour notice.

PATIENT SIGNATURE (Guarantor, if Patient is Minor): _____ **DATE**:_____

BURLINGAME
THERAPEUTIC
ASSOCIATES, II

Welcome to **Burlingame Therapeutic Associates, II**. Your physician has referred you with a diagnosis or you are here under "Direct Access" for physical therapy. Based upon this referral, our therapist will perform an evaluation, develop a treatment plan and treat your injury or disease. We will continually re-evaluate your progress and report your progress to your physician.

Physical therapy is for your benefit. Therefore, it is important for you to take an active role in your rehabilitation. During your physical therapy care, you will be asked to perform certain exercises at home. It is very important that you carefully follow the instructions given and perform the exercises, as they will facilitate your quick recovery.

Treatment goals and plan which are based on the evaluation will be reassessed and modified as appropriate. From time to time you may be asked to be seen by another Physical Therapist to carry out all the following elements of the preceding treatment plan and will notify the primary therapist if significant changes arise.

TREATMENTS are by appointments only. Our office is closed on most recognized holidays. It is very important to be prompt and keep your scheduled appointments. Patients that arrive later than 15 minutes past their scheduled appointment time may be required to reschedule. In consideration to our other patients, we require 24 hours advance notice to any appointment cancellation.

It is a requirement that we notify your physician, company nurse, insurance company, or industrial carrier about your physical therapy attendance.

IN CONCLUSION, our primary goal is to provide you with the highest quality physical therapy care and treatment possible, and to assist you in your speedy recovery. Please help us to assist you in your recovery by keeping all your scheduled physical therapy appointments and performing your home exercises as directed.

Eligibility and Benefits

The eligibility and benefits provided to Burlingame Therapeutic Associates II by your insurance company is only an estimate and does not guarantee payment for your physical therapy charges. Actual payment of the claim will be based upon the conditions once the claim is received and processed. Additional charges such as deductibles, copayments, coinsurance or other non-covered charges may apply according to your health plan benefits. If you would like more information about your benefits, please contact your health plan directly. The telephone number is located in the back of your insurance card.

No Show Policy

Burlingame Therapeutic Associates II will charge **$50.00** to patients who fail to keep appointments without 1 business day prior notification.

I understand and abide to the terms stated above.

Patient (Print Name): _____

Patient (Signature): _____

Date: _____

BURLINGAME THERAPEUTIC ASSOCIATES, II

Patient Privacy Notice

This abbreviated notice briefly describes how health information about you may be used and disclosed and how you can get access to this information. How we may use and disclose health information about you:

- **For Treatment:** We may use and disclose health information about you to provide you with health care treatment or services. We may disclose health information about you to personnel who are involved of taking care of you.
- **For Payment:** We may use and disclose health information about you so that the services you receive from us may be billed to insurance carriers and payment collected.
- **For Health Care Operations:** We may use and disclose health information about you for operations that are necessary to run our practice.
- **Health-Related Services and Treatment Alternatives:** We may use and disclose health information to tell you about health-related services.
- **Threat to Health or Safety:** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of public or another person.
- **Military and Veterans:** If you are a member of the armed forces or separated/discharged from military services, we may release health information about you, as required by military command authorities or the Department of Veteran's Affairs.
- **Workers' Compensation:** We may release health information about you for Workers' Compensation or similar programs.
- **Health Oversight Activities:** We may disclose health information to a health oversight agency, as authorized by law.
- **Laws and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose information about you in response to a court or administrative order, etc.
- **Law Enforcement:** We may release health information if asked to do so by a law enforcement official.

Your Rights Regarding Health Information About You:

- **Right to Inspect and Copy:** You have the right to inspect and copy health information that may be used to make decisions about your care.
- **Right to Amend:** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information.
- **Right to an Accounting of Disclosures:** You have the right to request a list accounting for any disclosures of your health information we have made, except for uses and disclosure for treatment, payment and health care operations, as previously described.
- **Right to Request Restrictions:** You have the right to request that we communicate with you about health matters in a certain way or at a certain location.
- **Right to a Paper Copy of This Notice:** You have the right to obtain a paper copy of the entire PHI Privacy Notice at any time.

We reserve the right to change this notice at any time. We will post a copy of the current notice in our facility. If you would like a complete copy of the Protected Health Information Privacy Notice, please ask the Patient Coordinator.

Patient Signature: _____ Date: _____

MEDICAL QUESTIONNAIRE

In an effort to provide you with physical therapy services in a safer treatment environment, please answer the following questions.

Have you ever been treated for or had any of the following conditions?

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	YES	NO
High Blood Pressure		
Fits or Convulsions		
Fever / Sweats		
Sudden Weight Loss		
Severe or Frequent Headaches		
Blackouts		
Loss of Strength or Numbness		
Loss of Vision		
Double Vision		
Unusual Bleeding		
Dizzy Spells		
Loss of Hearing / Ringing in the Ears		
Trouble Swallowing		
Goiter		
Thyroid Disease		
Hay Fever		
Persistent Cough		
Heart Trouble		
Shortness of Breath		
Ankle Swelling		
Chest Pain After Exercise		
Rapid or Skipping Heartbeat		
Rheumatic Fever		
Asthma or Wheezing		
Cardiovascular		
Do You Wear A Pacemaker?		

	YES	NO
Are you pregnant? (Females Only)		
Severe Indigestion / Heartburn		
Frequent Vomiting / Vomited		
Excessive Belching / Bloating		
Severe Stomach Pain		
Blood in your Stool?		
Severe Diarrhea		
Jaundice		
Burning or Painful Urination		
Trouble Starting Urine Flow		
Excessive Urination		
Blood, Stones, or Gravel in Urine		
Sexually Transmitted Disease / AIDS/ HIV		
Diabetes (Please Circle)	Type I	Type II
Skin Rashes		
Swollen or Painful Joints		
Arthritis or Rheumatism		
Nervous Disorder		
Depression		
Cancer		
Tuberculosis		
Heavy Smoking/ Drinking Habits		
Operation / Surgery in the Past 3 Years		
Hernia		
Coughing Up Blood		

Patient Name: _____

Date:_____

BURLINGAME THERAPEUTIC ASSOCIATES, II

MEDICATION LIST

Please list **ALL** medications that you are currently taking. Include dosage and frequency.

1._____

2._____

3. _____

4. _____

5. _____

6. _____

7. _____

8._____

9._____

10. _____

11._____

12. _____

13. _____

14. _____

15._____

Are there any other conditions you may have that we should be aware of? (Please list as many details as possible)

_____

_____

_____

_____

Patient Signature: _____ Date: _____