BURCH PHYSICAL THERAPY

PATIENT INFORMATION

(Must be updated every 365 days. Federal regulations require a medical history must be included in all patients' medical records in this office)

Date_____ Referring Physician_____

PATIENT'S LEGAL NAME_____

PREFERRED NAME_____ Sex: M □ F □

Social Security No._____ Age_____ Birth Date_____

Mailing Address_____

City _____ State_____ Zip_____ Marital Status: _____

Home Phone _____ Cell Phone _____

Email Address (*****) _____

*****Subscribe to Burch Physical Therapy's monthly Physical Therapy & Wellness Newsletter! Your email address will be kept completely confidential and is never shared in ***any*** way. You may unsubscribe at any time.

Employer*_____ Phone _____

Employer Address_____

City _____ State_____ Zip_____ Occupation_____

**If your treatment is under a workmen's compensation claim, list employer at time of injury*

EMERGENCY CONTACT: Name_____ Relationship_____

Phone _____ Alternate Phone _____

Date of Injury/Onset_____ Date of Surgery (if any) _____

Primary Insurance Carrier: _____

Who is the main policy holder? □ **Self** □ **Spouse** □ **Mother** □ **Father**

(If not self): Name_____ Birth Date_____

Secondary Insurance Carrier: _____

Who is the main policy holder? □ **Self** □ **Spouse** □ **Mother** □ **Father**

(If not self): Name_____ Birth Date_____

ON-THE-JOB INJURY: Is this a work-related injury or condition? Yes □ No □

Work Comp. Carrier_____ Claim #_____

Adjuster Name_____ Phone ()_____

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Are you **currently** receiving home health care? Yes ☐ No ☐
Have you had any Speech Therapy this calendar year? Yes ☐ No ☐

Do you now have, or have you had any of the following?

	Yes, No			Yes No			Yes No
Diabetes	☐	☐	Headaches	☐	☐	Other Allergies.	☐ ☐
High Blood Pressure.	☐	☐	Kidney Disease	☐	☐	Previous Surgery.	☐ ☐
Heart Disease	☐	☐	Nervous Disorders . . .	☐	☐	Hernia (Ventral/Inguinal)	☐ ☐
Heart Attack.	☐	☐	Stroke	☐	☐	Seizure	☐ ☐
Pacemaker.	☐	☐	Allergies to Heat/Ice...	☐	☐	Metal Implants.	☐ ☐
Cancer.	☐	☐					

If yes on any above, please explain and give approximate dates_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Have you had previous physical therapy or chiropractics for your present condition or for any other condition <u>this year</u>? Yes ☐ No ☐ *<u>If yes</u>*, state where, when, what treatment was given and for what condition: _____

_____

How did you select Burch Physical Therapy for your rehabilitation needs?

☐ Doctor ☐ Friend / Family ☐ Burch Website ☐ Returning Patient ☐ Facebook
☐ Yelp ☐ Phonebook ☐ Advertisement ☐ Other: _____

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The information provided herein is correct to the best of my knowledge.

As a service to our patients, we will be happy to submit an insurance claim to assist you in receiving your maximum insurance benefits. However, in the event of unpaid benefits by your insurance carrier(s), you will be responsible for the balance in full. Your insurance is a policy contract between you and your insurance carrier(s). We are not a party to that contract. If you have questions about why your insurance had paid or denied a certain amount or service, we encourage you to contact your insurance carrier(s). As a courtesy, we will obtain your physical therapy benefits and provide you with a breakdown of the coverage quote provided to us by your carrier(s).

I understand that I am financially responsible for all charges not covered by insurance. I will be responsible to BURCH PHYSICAL THERAPY, INC. for payment of the entire bill. I understand that I am financially responsible for all costs of collection, including reasonable attorney's fees and court costs. All copays and deductibles are due at the time of service. I understand and agree that any monies received over and above my indebtedness will be refunded when my bill is paid in full by any and all insurance companies.

WITH MY SIGNATURE I also give my consent to BURCH PHYSICAL THERAPY, INC. to administer the physical therapy as outlined by the referring physician to myself or my child, and I hereby authorize payment from my insurance companies directly to BURCH PHYSICAL THERAPY, INC.

Cancellation & No Show Policy

PLEASE REVIEW CAREFULLY

In order to provide you with the best care possible, we ask that you make every effort to keep your scheduled appointments and arrive in a timely manner. If you are unable to keep an appointment, please call us at 530-226-9242 a minimum of 24 hours prior to your scheduled appointment time so that we may reschedule you if necessary. **FAILURE TO CANCEL WITHIN THIS TIMEFRAME OR FAILURE TO ATTEND A SCHEDULED APPOINTMENT WITHOUT NOTIFICATION ("NO SHOW") WILL RESULT IN A $75.00 FEE.**

Payment of cancellation and missed appointments are due at your next scheduled appointment. We realize that on occasion emergencies and unforeseen illnesses may arise and may be waived on a case by case basis.

I HAVE READ, UNDERSTAND, AND AGREE TO THESE OFFICE POLICIES:

PATIENT SIGNATURE _____ DATE _____
(if minor, parent/guardian signature)

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PATIENT ACKNOWLEDGEMENT Health Insurance Portability and Accountability Act (HIPAA)

Our ***Notice of Privacy Practices provides*** information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this acknowledgement. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

The complete Notice of Privacy Practices in available in our main lobby for your review. If you would like to receive a copy of the Summary and complete Notice, please request a copy at the front desk.

If you wish for persons other than those released under normal operations as indicated in the Notice to receive confidential information that is now protected under HIPAA, you must release them in writing. Please indicate on this form your spouse or any other family or friends whom you wish to be able to receive information about you. You may of course choose not to release your information to anyone. You may also be more specific in your restrictions for the persons you have released, just provide that request in writing. Parents or Guardians of minor children do not need to be released.

Please be aware that our staff has to follow federal law on information that we release by phone and we may at any time choose not to release information of any kind by phone if we feel that the person requesting information is not authorized or we feel the information may be too sensitive to release by phone.

By signing this form, you are acknowledging that Burch Physical Therapy, Inc. has made our Notice of Privacy Practices available to you for review and that we have offered you a personal copy.

In an effort to protect your healthcare information yet give you choices, please list any/all names and relation of those whom we have your permission to discuss appointment dates, times, billing, and medical information. (Example: spouse, significant other, parents, step-parents, other physicians, caretaker).

_____	_____
Name	Relation
_____	_____
Name	Relation
_____	_____
Name	Relation

I fully understand and accept the terms of this consent.

PATIENT SIGNATURE _____ DATE _____
(if minor, parent/guardian signature)

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APPOINTMENT REMINDER CONSENT (*OPTIONAL*)

NAME: _____

Please complete this form and sign below to give your permission for Burch Physical Therapy, Inc. to provide automatic appointment reminder service by email or by cell phone text message.

Please select only ONE option below:

☐ Burch Physical Therapy, Inc. may send **email** messages to confirm my upcoming appointments. Please email reminders to: _____

-OR-

☐ Burch Physical Therapy, Inc. may send cell phone **text messages** to confirm my upcoming appointments. Please text reminders to: (_____) _____-_____

If you would like text messages instead of email reminders, please indicate your cell phone carrier.

Please indicate your carrier below if you would like text message reminders:

☐ ALL Tel
☐ AT & T
☐ Boost Mobile
☐ CellCom
☐ Cingular
☐ Cricket Wireless
☐ Metrocall
☐ MetroPCS
☐ Nextel
☐ Qwest
☐ Simple Mobile
☐ Sprint PCS
☐ T Mobile
☐ US Cellular
☐ Verizon
☐ Virgin Mobile

PATIENT SIGNATURE _____ DATE _____ *(if minor, parent/guardian signature)*

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Please list all medications, including all prescriptions, over the counter medications, herbals, vitamins, minerals, and dietary supplements. Include the dosage, frequency and administration method for each medication. YOU MAY DUPLICATE THIS PAGE IF NECESSARY.

Medication	Dosage	Frequency	Method of Administration
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:

PATIENT SIGNATURE ________________________________ DATE ____________

(if minor, parent/guardian signature)

Reviewed by: ____ Date: ________________

Rev. 6.30.2020