

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 . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Headaches . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Other Allergies. . . . .	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure. . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Previous Surgery. . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Disorders . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Hernia (Ventral/Inguinal)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack. . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Stroke . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Seizure . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker. . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Heat/Ice...	<input type="checkbox"/>	<input type="checkbox"/>	Metal Implants. . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Cancer. . . . .	<input type="checkbox"/>	<input type="checkbox"/>						

**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 this year?** Yes  No  *If yes*, 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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**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 is 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
		<input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other:
		<input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other:
		<input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other:
		<input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other:
		<input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other:
		<input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other:
		<input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other:



**PATIENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

*(if minor, parent/guardian signature)*

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

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## Financial Responsibility Information

It is the responsibility of the patient to know their insurance policy(s). Your insurance policy is a contract between you and your insurance carrier(s). If you have questions about how your insurance processes your claims or denies treatment, we encourage you to contact your insurance carrier(s). **It is your responsibility to review your insurance information prior to your physical therapy treatment.** As a courtesy, we will obtain your physical therapy benefits and provide you with an explanation of the coverage quoted to us by your insurance carrier(s). Any information provided to you is an **estimate**, which has been provided to our office by your insurance company.

As a service to our patients, we are happy to submit an insurance claim to assist you in receiving your maximum benefits from your policy. **These claims are subject to insurance processing and the results from processing may vary.**

**\*\*In the event of unpaid benefits by your insurance carrier(s), you will be responsible for the balance in full.\*\***

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. I understand that I am financially responsible for any balance remaining from my insurance carrier(s) processing of claims. **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.

**I HAVE READ, UNDERSTAND, AND AGREE TO THESE RESPONSIBILITIES:**



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## Cancellation & No-Show Policy

*👉* **PLEASE REVIEW CAREFULLY** *👈*

We take pride in providing physical therapy to our patients. 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 appointment fees are due at your next scheduled appointment. We realize that on occasion emergencies and unforeseen illnesses may arise and fee may be waived on a case-by-case basis.

As a courtesy, a copy of this policy will be given to any patient or responsible party upon request. Please understand that this is our office policy and a signature is requested to note knowledge, and understanding of this policy, but not a requirement for enforcement of this policy.

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



**PATIENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

*(if minor, parent/guardian signature)*