Butte Premier Physical Therapy
Patient Information Form
General Information

Name:__________________________________ Birthdate:_____/_____/_____ Age:_____
Address:____________________________________ City:__________ Zip:___________
Home Phone:_________________ Work Phone: __________________ Sex: Male Female
Social Security:_____-____-_______ Marital Status: Single Married Divorced Widowed
Date of Injury:___________ How it happened:___________________________________
Emergency Contact:_____________________________________Phone:_____________
Who may we thank for your referral?____

Insurance Information

Medicare	**Medicare#:**	**Effective Date:**		
Workers Comp/ Auto Accident	**Name of Insurance:**	**Address of Insurance:**		
	Claim #:	**Date of Injury:**	**Adjuster:**	**Phone:**
	Case in litigation:	**Name of Attorney:**		**Attorney Phone:**
Other Insurance		**Insurance Name:**		
		Insurance Address:		
	Insurance Phone:	**Subscriber:**		**Relationship:**
	ID #:	**Group #:**		**Reference/Auth #:**

Financial Policy

BILLING: As a courtesy to our patient, Butte Premier Physical Therapy will bill all primary and secondary insurance companies. Please provide us with complete and accurate insurance information, as well as any change of address, telephone number or employer.

RESPONSIBILITY: Your insurance coverage is a contract between you and your insurance company. You are responsible for payment of your account. If your deductible has not been met, full payment of your office visit is required. If your deductible has been met, you are required to pay the percentage not covered by your insurance carrier, or your co-pay upon arrival for all therapy visits (unless arrangements are made). If you have a question regarding insurance payments, or the extent of services covered under your insurance plan, please contact your carrier regarding coverage.

Consent

I hereby consent to examination and treatment by Butte Premier Physical Therapy, Inc. and authorize Butte Premier Physical Therapy, Inc. to use or share my protected health information with the school athletic trainer or coach, and to obtain payment for my bills and to conduct its healthcare operations and business. I authorize payment to be made directly to Butte Premier Physical Therapy, Inc., including Medicare, or other benefits payable from any source, for all services rendered. I understand that I am ultimately responsible for payment of my account, and accept full responsibility for the cost of all services. I understand a 24-hour notice must be given when canceling an appointment or a charge may be added to my account. I realize that I have the right to refuse any procedure after having the risks and benefits explained to me.

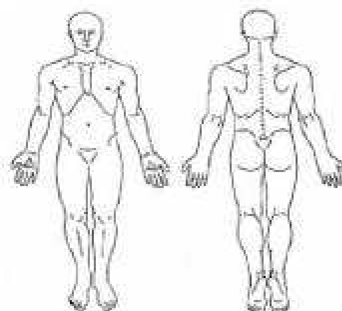
Signature:____ Date:_________________

Butte Premier Physical Therapy
Medical History Form

Name:____ **Date:_____________________**

Indicate where your pain is located and what type of pain you feel at the present time. Use the symbols below to describe your pain. Do not indicate areas of pain not related to your present injury or condition.

/// : Stabbing
XXX : Burning
OOO : Pins & Needles
=== : Numbness
+++ : Achey



Past Medical History

Please circle each condition that you have been told you have (or had).

Cancer Diabetes Kidney Disease Liver Disease Stroke
High Blood Pressure Heart Disease Angina/Chest Pain Ulcers Fibromyalgia
Osteoporosis Osteoarthritis Rheumatoid Arthritis Sexually Transmitted Disease
Allergies/Asthma Lung Disease

Have you had a recent illness (explain if yes)? _______________
Do you take blood thinners? YES NO Are you allergic to latex? YES NO Other:

Currently I am experiencing (circle all that apply)

Fever/chills/sweats Poor balance (falls)
Unexplained weight loss Numbness or Tingling Changes in appetite Difficulty swallowing
Depression Shortness of breath Dizziness Headaches
Changes in bowel or bladder function Nausea /Vomiting Increased pain at night

During the past month, have you often been bothered by feeling down, depressed, or hopeless? YES NO
During the past month, have you often been bothered by little interest or pleasure in doing things? YES NO

Current Symptoms

Where are you currently having symptoms? ____
What date (approximately) did your present pain start?_____________________________________
How (gradually, suddenly, injury)?____
My symptoms are currently: **Getting better / About the same / Getting worse**
Have you received any treatment for this problem?_______________________________________
Have you ever had this problem before: **YES** / **NO**
If so, how was the problem treated?____
How long did it take for you to feel better? ____
What is your personal goal for therapy? ____

Consent

I understand that my diagnosis & treatment plan will be discussed during my appointment and that I have the right to question and/or refuse any treatment offered.

Signature:______________________________________ **Date:________________________**

Butte Premier Physical Therapy
125 Raley Blvd
Chico, CA 95928
(530) 891-8220 – Fax (530) 891-8226

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

- The patient understands and agrees to allow this physical therapy office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this physical therapy office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
- The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
- A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
- The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
- For your security and right to privacy, all staff has been trained in the area of patient record privacy. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
- Patients have the right to file a formal complaint with our office about any possible violations of these policies and procedures.
- If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, this office has the right to refuse to provide care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

____________________________	____________________________
Patient Signature	Date
Patient Name (printed)	Witness