Welcome to ***Burbank Physical Therapy & Wellness!*** Thank you for choosing us as your physical therapy/fitness provider. Our staff is committed to serving you and making your rehabilitation experience enjoyable and successful. Please take a few minutes to read this information so that you can become familiar with our practice. We will be happy to answer any questions you have on an individual basis.

Mission Statement

Burbank Physical Therapy & Wellness is committed to excellence in the provision of physical therapy and wellness services to our valued clients and referring physicians. We strive to provide an exemplary model of physical therapy and fitness in a professional, caring, results-effective, cost-effective environment. Our goal is to assess each patient to return to their highest functional level in work, sports or recreation. We will provide outstanding service to our clients utilizing an individualized, goal-oriented approach and dedication to provide them the foremost expertise that physical therapy has to offer.

Office Hours and Appointments

Monday, 3:00 PM – 7:00 PM
Tuesday, 7:00 AM – 7:00 PM
Wednesday, 7:00 AM – 7:00 PM
Thursday, 7:00 AM – 7:00 PM
Friday, 7:00 AM – 3:00 PM
Saturday, 7:00 AM – 1:00 PM

Office hours are by appointment only. We appreciate your personal schedules and will make every effort to accommodate your special scheduling needs. We require 24-hour notice for any schedule changes.

Attire

Please dress comfortably as if you were going to exercise.

A Word about Physical Therapy

In the state of California physical therapists can see you without a medical referral. However, for physical therapy injury treatment a diagnosis must be in place. If you have a specific injury, you'll need a referral and diagnosis from a medical doctor or chiropractor. Most insurance companies require a physical therapy prescription that documents "medical necessity" for treatment. However, for fitness purposes, performance, wellness or maintenance visits, a physical therapy prescription is not needed. These visits are not considered medically necessary, therefore not reimbursable by insurance and payment is due at time of service.

Many people seek physical therapy with declining function, whether it be a postsurgical issue, an acute injury/trauma, chronic disease or condition, deconditioning, complex pain, stress overload, or repetitive overuse injuries. These situations may be reimbursed by some insurance plans. Physical therapy treatment involves mobility planning/skilled interventions, and is based on movement impairment models. Goals are established at the time of examination and will relate to improving one's physical functioning.

When your therapist believes you have obtained your functional goals and improved functional status related to activities of daily living, or you plateau with progress, medical insurance no longer applies. We as physical therapists are required to practice within this context.

If you elect to continue with our care, we are able to see you on a payment at time of service basis. Many of our patients become lifelong clients and continue with visits for prevention, maintenance and performance. This may include consults, active release, exercise programming, Pilates and fitness training at BURBANK PHYSICAL THERAPY & WELLNESS.

BURBANK PHYSICAL THERAPY & WELLNESS is committed to providing our patients with the highest quality care. We thank you for taking the time to read and understand our policies.

OFFICE POLICIES

Scheduling

When using insurance, a current prescription signed by a medical doctor, and updated every 30 days, is required for treatment. If treatment continues for a prolonged period, prescriptions must be updated regularly and coordinated with your medical doctor. You are responsible for these updates. Let us know when you will be seeing your physician so we can have a progress report ready.

A Word About Insurance

We accept many health plans as either an in-network or out of network provider. We currently do not accept Medicare. If you have a personal injury/automobile accident with individual coverage or have a Work Comp injury, we will submit these claims and bill directly for you based on our ability to obtain prior authorization for your treatment.

Physical therapy coverage is often confusing. Although we can assist you with your insurance questions, it is strongly suggested that you contact your insurer directly to determine your coverage for outpatient physical therapy. You may be required to make deductible or co-insurance payments as part of your coverage. Customary method of billing for physical therapy services is based on the amount and type of services you receive; therefore, we cannot tell you exactly how much your treatments will cost. However, once we have verified your coverage, we can notify you of your approximate coverage. Please feel free to talk to our billing staff regarding your insurance questions.

You may or may not carry insurance under which a percentage of our fees are covered. You should know that all professional services provided by BPT are charged directly to the patient, and that he or she (or the financially responsible party) is personally responsible for payment. While we cannot render service on the assumption that our fees will be paid by an insurance company, we will help prepare your insurance claim forms to confirm services payable by your insurance company.

Patients are responsible for services not covered by insurance; including care that their insurance deems is **"not medically necessary"** even though a physician may recommend the treatment.

Overall, patients are ultimately responsible for knowing the details of their coverage (e.g., percent of coverage, deductibles, co-payments, limits on number of visits or dates of coverage, your referring physicians' or our status as a preferred provider, etc.), which may determine the extent of your financial responsibility.

We do not accept liens against pending litigation settlements.

Financial Payment Arrangements

It is our policy in this office to maintain your account on a current basis. **Charges for treatment are due at the time the service is provided unless arrangements are made in advance.** We ask that you make co-payments, co-insurance and deductibles at the time of each visit. Your balance must be paid in full on or before the 1st day of the following month, and any unpaid balance will be considered past due on the 5th of the month. An interest charge of **1%** per month may be applied to all past due balances.

Voluntary Termination of Care

It is also the policy of this office that if you should choose to suspend or terminate your care and treatment, any outstanding fees for professional services rendered to you will be immediately due and payable.

It is the patient's responsibility:

- To know their insurance policy. Patients should be aware of their benefit coverage including which healthcare providers are contracted with their plan, covered and non-covered benefits, authorization requirements, and cost share information such as deductibles, coinsurance, and co-payments. If you are not familiar with your plan coverage, we recommend you contact your carrier directly.
- To obtain a referral from their Primary Care Physician (PCP) and/or obtain authorization for treatment from their insurance carrier prior to receiving services. Any non-covered services are the financial responsibility of the patient.

- To pay their co-payment at the time of service, estimated co-insurance amount, and deductibles.
- To promptly pay any patient responsibility indicated by their insurance carrier.
- To facilitate in claims payment by contacting their insurance carrier when claims have not been paid.

It is BURBANK PHYSICAL THERAPY & WELLNESS Physical Therapy's responsibility:

- To provide quality medical care.
- To file insurance claims as a courtesy to the patient. A 60-day period will be extended for pending insurance payment, after which the patient may be held responsible for the entire balance.
- To provide superbill for submission to insurance if we are not part of insurance network.

Cancellations and No-Shows

We require 24 hours notice in the event of cancellation. There is a full $35 service fee for no-shows or cancellation without proper notice. This charge is not covered by your insurance and is billed directly to the patient, and will be collected at the time of the next scheduled appointment. Repeated missed appointments may warrant discontinuance of care.

Financial Policy Acknowledgment:
I have read and understand the above financial policies and the cancellation policy. I agree to pay for the missed appointment fee and understand that, regardless of my insurance claim status or absence of insurance coverage, I am ultimately responsible for the balance on my account for any services rendered.

____ ____________________

Patient or Responsible Party Signature Date

Release of Medical Information and Assignment of Benefits:
I authorize the release of medical information necessary for filing health insurance claims for me by Burbank Physical Therapy & Wellness. I also authorize my insurance carrier(s) to make payment directly to Burbank Physical Therapy & Wellness.

____ ____________________

Patient or Responsible Party Signature Date

I have read and agree to the above policies.

____ ____________________

Patient/Guardian Signature Date

PATIENT MEDICAL HISTORY

Patient:____ Home Phone: (____)______________________

Birth date:___________ Work Phone: (_____)_____________ Cell Phone: (____)________________________

Address:____City:______________State:_______Zip:________

Social Security Number:_______________________________Email Address:_____________________________

Employer:____
Address State Zip

Emergency Contact: Name____________________________________Phone #:____________________________

Address:____

Your goals for physical therapy:____

Athletic goals:__________________________________How did you hear about us?_______________

Were you referred to a particular practitioner? If so, who?_____________________________________

Referring Physician:__________________________________ Phone: (____)______________________________

Address:____

When do you see your physician again?__________________

Primary Care Physician:_______________________________ Phone: (____)______________________________

Type of Injury/Condition:____________________________________ Onset/Injury Date:___________________________

Physical limitations due to injury____

What activities aggravate your symptoms? ____

____

Type of Surgery & Date:____:___________

Describe any previous treatment for this condition:

____

____

Have you had any diagnostic tests for this condition?

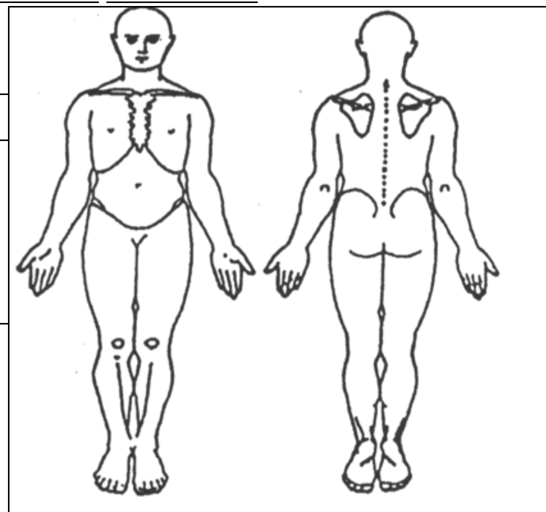
X-ray CT scan MRI Doppler Ultrasound

Please describe your pain: Sharp / Burning / Aching /

Tingling / Numbness / Other_____________________________

Please rate your pain (0 = none, 1 = minimal, 10 = severe):

At present: 0 1 2 3 4 5 6 7 8 9 10
At its worst: 0 1 2 3 4 5 6 7 8 9 10
At its best: 0 1 2 3 4 5 6 7 8 9 10



Please mark the location of your symptoms or problem

Are you currently taking medications: Yes / No

Please list meds: ____

Have you recently noted any of the following?

- ❒ Breathing Difficulty
- ❒ Change in Vision
- ❒ Fatigue
- ❒ Fever/Chills/Sweats
- ❒ Headaches
- ❒ Insomnia
- ❒ Nausea/Vomiting
- ❒ Pain at Night
- ❒ Pregnancy
- ❒ Weakness
- ❒ Weight Loss

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

- ❒ Allergies/Skin Sensitivity
- ❒ Asthma/Breathing Problems
- ❒ Autoimmune Deficiency
- ❒ Cancer
- ❒ Circulation Problems
- ❒ Diabetes
- ❒ Easy Bruising/Bleeding
- ❒ Fainting
- ❒ Fractures
- ❒ Heart Problems
- ❒ Hepatitis
- ❒ High Blood Pressure
- ❒ Indigestion/Heartburn
- ❒ Kidney Disease
- ❒ Leg/Ankle Swelling
- ❒ Loss of Consciousness
- ❒ Lung Disease
- ❒ Metal Implant
- ❒ Motor Vehicle Accident
- ❒ Multiple Sclerosis
- ❒ Osteoporosis/Osteopenia
- ❒ Sprains/Strains
- ❒ Stroke
- ❒ Surgeries
- ❒ Thyroid Problems
- ❒ Urinary Problems/Infections

❒ Any previous injury that may affect current care? Please describe: ____________________________

Please explain & give approximate dates for any conditions marked above. ____________________________

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____

INSURANCE INFORMATION

Insurance Carrier____________________________ Phone: (   )____________________

Address:____

Claim Number____________________________ Group Number____________________

Date of Injury______________ Adjustor or Contact Person____________________________

Name of Insured____________________________ Relationship to Patient________________

Birth Date of Name of Insured____________________

Additional Insurance Coverage____________________ Claim Number ____________________

Address____________________________________Phone Number (   )________________

Did this accident occur at work? YES or NO   Were you involved in an automobile accident? YES or NO

Financial Class:

❒ Insurance ❒ In Network ❒ Out of Network   ❒ Wellness/Cash

❒ Workers' Comp   ❒ Other (select one): __Auto __Medicare

Dx: ____________________________________

Physical Therapist: Michelle P. Tamondong, MPT

Blue Shield members are required by Blue Shield Insurance Company to fill out additional self-assessment forms. Please plan to arrive 15 minutes prior to your scheduled first appointment to complete the paperwork.

PATIENT HEALTH QUESTIONNAIRE – PHQ (REQUIRED FOR BLUE SHIELD PATIENTS)

Patient Name____ Date_______________________________________

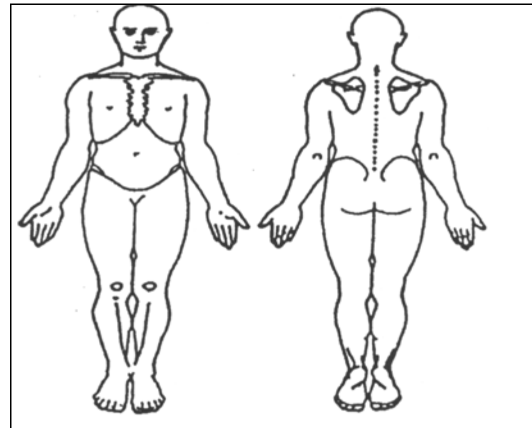
1. Describe your symptoms ____

____

a. When did your symptoms start? ____

b. How did your symptoms begin? ____

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms.
   - (1) Constantly (76-100% of the day)
   - (2) Frequently (51-75% of the day)
   - (3) Occasionally (26-50% of the day)
   - (4) Intermittently (0-25% of the day)



Please mark the location of your symptoms

3. What describes the nature of your symptoms?
   - (1) Sharp (4) Shooting
   - (2) Dull ache (5) Burning
   - (3) Numb (6) Tingling

4. How are your symptoms changing?
   - (1) Getting Better
   - (2) Not Changing
   - (3) Getting Worse

5. During the past 4 weeks: None ... Unbearable
   - a. Indicate the average intensity of your symptoms (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
   - b. How much has pain interfered with your normal work (including both work outside the home, and housework)?
     (1) Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities? (like visiting with friends, relatives, etc.)
   (1) All of the time (2) Most of the time (3) Some of the time (4) A little of the time (5) None of the time

7. In general would you say your overall health right now is…
   (1) Excellent (2) Very Good (3) Good (4) Fair (5) Poor

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8. Who have you seen for your symptoms? (1) No one (2) Medical Doctor (3) Chiropractor (4) Physical Therapist

   Other____

a. What treatment did you receive and when?____

b. What tests have you had for your symptoms and when were they performed? (1) X-rays date:________ (3) CT Scan date:_____________ (2) MRI date:________ (4) Other___ date:_____________

9. Have you had similar symptoms in the past? (1) Yes (2) No

   a. If you have received treatment in the past for the same or similar symptoms, who did you see? (1) This Office (3) Physical Therapist (2) Chiropractor (4) Medical Doctor

   Other____

10. What is your occupation? (1) Professional/Executive (2) White Collar/Secretarial
   (3) Tradesperson (4) Laborer (5) Homemaker
   (6) FT Student (7) Retired (8) Other_________________________________

   a. If you are not retired, a homemaker, or a student, what is your current work status?_______________________

Patient Signature____ Date: ___________________________________

BURBANK PHYSICAL THERAPY & WELLNESS, INC

HIPAA REGULATIONS

Privacy Practices

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

Our Legal Duty

The law requires us to: 1) Keep your medical information private. 2) Give you notice describing our legal duties and privacy practices. 3) Notify you of any changes in our privacy practices.

Use and Disclosure

To follow are different ways that we are permitted to use and disclose medical information. We will not use or disclose any medical information not listed without specific written authorization from you.

Treatment: We may use medical information about you to provide you with medical treatment or other services related to your care. We may disclose medical information about you to doctors, nurses, technicians or other people involved in your care. We may also share medical information about you to *your* other health care providers to assist them in treating you.

Payment: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third party payer (i.e., insurance company, attorney, consulting physician). We may also disclose information to your health plan about treatment or possible treatment to help determine if your health plan will pay for certain services.

If you have any question about any of our policies or your rights, please feel free to speak with your physical therapist or any of our staff.

Your signature below indicates your understanding and compliance of the above privacy practices.

____ _____________________

Printed Name Date

____

Signature