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 (*****) _________________________________

Emergency Contact: Name_______________________ Relationship_____________

Phone ______________________ Alternate Phone ____________

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 (____)_______________________

Date of Injury/Onset_________________________Date of Surgery (if any) _________________

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

Employer*____ Phone _______________

Employer Address____

City _____________________ State_____ Zip______ Occupation______________________

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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 currently 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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MEDICATION LIST

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 sign

Rev. 03.24.2025

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)

BURCH PHYSICAL THERAPY
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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)*

Rev. 03.24.2025

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.***

I understand that I am financially responsible for all charges not covered by insurance. **In the event of unpaid benefits by your insurance carrier(s), you will be responsible for the balance in full.** 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.

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

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 BURCH PHYSICAL THERAPY, INC to bill and receive payment from my insurance company.

I HAVE READ, UNDERSTAND, AND AGREE TO THESE RESPONSIBILITES:

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

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)

RELEASE AND WAIVER OF LIABILITY, ASSUMPTION OF RISK AND INDEMNITY AGREEMENT

IN CONSIDERATION of being permitted to enter the BURCH PHYSICAL THERAPY (BPT) for any purpose, including but not limited to, observation, use of facilities or equipment, or participation in any way, the undersigned, for himself or herself and any personal representatives, heirs, and next of kin, hereby acknowledges, agrees and represents that he or she has, or immediately upon entering will, inspect such premises and facilities. It is further warranted that such entry into BPT for observation, participation or use of any facilities or equipment constitute an acknowledgment that such premises and all facilities and equipment thereon have been inspected and that the undersigned finds and accepts same as being safe and reasonably suited for the purposes of such observation or use.

IN FURTHER CONSIDERATION OF BEING PERMITTED TO ENTER BPT FOR ANY PURPOSE INCLUDING, BUT NOT LIMITED TO, OBSERVATION, USE OF FACILITIES OR EQUIPMENT, OR PARTICIPATION IN ANY WAY, THE UNDERSIGNED HEREBY AGREES TO THE FOLLOWING:

1) THE UNDERSIGNED HEREBY RELEASES, WAIVES, DISCHARGES AND COVENANTS NOT TO SUE Burch Physical Therapy, Inc., their directors, officers, shareholders, employees, independent contractors and agents (hereinafter collectively referred to as "releasees") from all liability to the undersigned, his/her personal representatives, assigns, heirs, and next of kin for any loss or damage, and any claim or demands therefor on account of injury to the person or property or resulting in death of the undersigned, whether caused by the negligence of the releasees or otherwise while the undersigned is in, upon, or about BPT premises or any facilities or equipment located therein.

2) THE UNDERSIGNED HEREBY AGREES TO INDEMNIFY AND SAVE AND HOLD HARMLESS the releasees and each of them from any loss, liability, damage or cost he/she may incur due to the presence of the undersigned in, upon or about BPT premises or in any way observing or using any facilities or equipment of BPT whether caused by the negligence of the releasees or otherwise.

3) THE UNDERSIGNED ACKNOWLEDGES AND UNDERSTANDS that physical activity, by its very nature, carries with its certain inherent risks that cannot be eliminated regardless of the care taken to avoid injuries. BPT has facilities for and provides for activities such as weightlifting, walking, jogging, running, aerobic activities and swimming. Some of these activities involve strenuous exertions of strength using various muscle groups, some involve quick movements involving speed and change of direction, and others involve sustained physical activity which places stress on the cardiovascular system.

The specific risks vary from one activity to another, but in each activity the risks range from 1) minor injuries such as scratches, bruises and sprains to 2) major injuries such as eye injury

or loss of sight, joint or back injuries, heart attacks and concussions to 3) catastrophic injuries including paralysis and death.

I have read the previous paragraphs and I know, understand and appreciate these and other risks that are inherent in the activities made possible by BPT. I hereby assert that my participation is voluntary and that I knowingly assume all such risks.

4) THE UNDERSIGNED HEREBY ASSUMES FULL RESPONSIBILITY FOR AND RISK OF BODILY INJURY, DEATH OR PROPERTY DAMAGE due to the negligence of releasees or otherwise while in, about or upon the premises of BPT and/or while using the premises or any facilities or equipment located therein.

THE UNDERSIGNED further expressly agrees that the foregoing RELEASE AND WAIVER OF LIABILITY, ASSUMPTION OF RISK AND INDEMNITY AGREEMENT is intended to be as broad and inclusive as is permitted by the law of the State of California and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

THE UNDERSIGNED HAS READ AND VOLUNTARILY SIGNS THIS RELEASE AND WAIVER OF LIABILITY, ASSUMPTION OF RISK AND INDEMNITY AGREEMENT and further agrees that no oral representations, statements or inducement apart from the foregoing written agreement have been made. I further acknowledge that I am signing this RELEASE AND WAIVER OF LIABILITY, ASSUMPTION OF RISK AND INDEMNITY AGREEMENT freely and voluntarily and intend my signature to be a complete and unconditional release of all liability, whether caused by the negligence of the releasees or otherwise, to the greatest extent allowed by law.

PATIENT SIGNATURE________________________________DATE______________

(if minor, parent/guardian signature)

AUDIO RECORDING CONSENT FORM

I, ____, acknowledge and understand that **Burch Physical Therapy** will be using PredictionHealth's AI scribing software service (the "Software"), during our visits moving forward. This Software will record and process the audio of our conversation to auto-generate the Provider's documentation and administrative work to help ensure the highest quality of care possible.

By signing this Audio Recording Consent Form, I expressly certify that I understand that:

A. The Provider will be using the Software to capture conversations between myself and the Provider in order to auto-generate the Provider's documentation and administrative work.

B. The audio will be processed by the Software and will record my protected health Information.

C. The audio recording will be used for clinical purposes only, including treatment, payment or health care operations in accordance with the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). It will not be used for any other purposes, including, for example, sharing, selling or using the audio recording for advertising purposes not in accordance with HIPAA.

D. The audio recording will be stored securely as part of my medical record in accordance with the applicable security regulations of HIPAA.

I have read all of the information above, or it has been read to me. I have had the opportunity to ask questions about it and any questions that I have asked have been answered to my satisfaction. By signing below, I expressly consent to the use of the Software and to have the audio of my visits recorded to support my Provider's clinical work.

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

PATIENT SIGNATURE______________________________DATE______________

(if minor, parent/guardian signature)

If this Audio Recording Consent Form is being completed by a person with legal authority to act on the patient's behalf, such as a parent or legal guardian of a minor health care agent, please complete the following:

____
Name of Person Completing Form and Relationship to Patient

_____________________________ ______________ ____________________
Signature of Person Completing Form Date Patient Date of Birth