Karen L. Bustillo, PT, DPT, OCS, P.L.L.C
dba Bustillo Physical Therapy
201 W. Guadalupe Rd., #313
Gilbert, AZ 85233
480-892-0808

PATIENT INTAKE

Last Name _____ First Name _____ MI _____

Date of Birth _____ Age _____ Gender _____ Marital Status _____ Home Number _____ Cell Number _____ Work Number _____

Address _____ City _____ State _____ Zip Code _____

Employer _____ City _____ State _____ Zip Code _____

How did you hear about us? _____

Appt Reminders: Email or cell number with service provider. (Verizon, Sprint, AT&T, etc) _____

Emergency Contact _____ Relationship _____ Phone Number _____

MEDICAL INFORMATION

Complaint/Injury _____ Date of injury/onset _____

If Surgery, Type _____ Date of surgery _____

Is this related to An Auto Accident? Yes ○ No ○

Referring Physician _____ Office Number _____ Location _____

Primary Care Physician _____ Office Number _____ Location _____

PRIMARY INSURANCE

Insurance Company	Insurance Phone Number	Insured Name	Relationship	Insured DOB

Insured ID #	Insured Group #	Insured Employer

SECONDARY INSURANCE

Insurance Company	Insurance Phone Number	Insured Name	Relationship	Insured DOB

Insured ID #	Insured Group #	Insured Employer

AUTHORIZATION TO PAY

I hearby authorize payment to be made directly to Bustillo Physical Therapy for any medical benefits otherwise payable to me for services. I understand that I am financially responsible for the charges not covered by my insurance.

Insurance verified by Bustillo Physical Therapy Office Staff- For Office Use Only:

Your Benefits: Co-pay: $_____ Deductible: $_____ Met YTD: $_____ Co-Insurance%: _____

Visit Limitations: _____ Verified by: _____ Date: _____

This is an estimation of benefits and not a guarantee of payment as noted by your insurance company. Benefits listed were obtained from a customer service representative with your insurance company or were obtained in detail from their website.

Bustillo Physical Therapy verifies your insurance benefits as a courtesy to you. We do not accept responsibility for the accuracy of the information provided by your insurance company. If you have further questions or concerns regarding your benefits, please contact our billing specialist or your insurance company directly.

I, _____, have read and understand the above information.

_____

Patient/Financial Party Signature Date

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Payment Policy

As a courtesy to all our patients, we bill your insurance company after coverage has been verified. It is your, as the patient, responsibility to know and understand what your insurance company does and does not cover. Bustillo Physical Therapy verifies insurance coverage on all its patients including deductibles, co-insurance, and office copay amounts. Bustillo Physical Therapy notifies each patient in writing of their benefit coverage. However, Bustillo Physical Therapy does not accept the responsibility for the accuracy of the information provided to us by your insurance company. In any event, the entire bill is the patient's responsibility. Any overpayment will be promptly refunded.

Our contract with your insurance company dictates that we collect the specified copayment at the time of service.

****Copays are due at the time of each visit****

We accept cash, personal checks, VISA and MasterCard.

There is a $35.00 fee for all returned checks.

Deductible and co-insurance amount are billed monthly once your insurance company has processed your claim. Payment in full is due within 20 days of the statement date. Those accounts not paid in full after the due date will incur an interest charge of 10% per year on the principal balance. In the event that payment is not made on this account and it is placed with a licensed collection agency, you are responsible for 100% of the collection costs, reasonable attorney fees and other costs that may be incurred to enforce collection of any amounts outstanding. Up to 50% of the patient's principal balance due will be added to the collection fees once the account is forwarded to the collection agency.

I have read and understand the payment policy.

_____ _____

Patient/Guardian Date

Cancellation, No Show & Late Policy

We are aware that sometimes it is impossible to keep your scheduled appointment. However, we request that you inform us 24 hours in advance so we may schedule another patient in your place. If you are more than 15 minutes late to your appointment, you may be asked to reschedule your appointment. We have an answering machine available for messages after hours and on weekends. If you do not inform us and do not show for your appointment, there will be a $50.00 charge billed directly to you. Your insurance will not pay for this fee. This policy helps us serve all our patients effectively. Thank you for your cooperation.

I have read and understand the cancellation policy.

_____ _____

Patient/Guardian Date

HIPAA CONSENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

-Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
-Obtain payment from third-party payers.
-Conduct normal health care operations such as quality assessments and physician certifications.

I have been informed by Bustillo Physical Therapy of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices from time to time and that I may contact Bustillo Physical Therapy at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

_____

Patient/Guardian Date

Children Policy

Your children's safety is our primary concern. Children who are not receiving physical therapy should have a quiet activity to play with them to play with while their parent or sibling is having their therapy. Our equipment looks fun and it enticing. It is for therapeutic purposes and not for play. **I hold Bustillo Physical Therapy harmless of any liable which is caused by not adhering to this policy.** Your cooperation with our policy is greatly appreciated.

_____

Patient/Guardian Date

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Health History Form

Name: _____ **Date:** _____

Age:_____ **Height:** _____ **Weight:** _____ **Sex:** **M** **F**

Right Handed: _____ **or Left Handed:** _____

Area Treating: _____

Medications (including prescription, supplements and over the counter drugs): _____

_____

Allergies (medications and other irritants): _____

Do you currently have any illness that we need to be aware of before treatment? _____

Have you ever been to physical therapy before? _____ **When and where?** _____

Please rate your health: _____ **Excellent** _____ **Good** _____ **Fair** _____**Poor**

Have you fallen in the past year? _____**Yes** _____ **No**

Do you smoke tobacco? _____ **Yes** _____**No** **If Yes:** _____ **Cigarettes** _____**Cigars** _____**Other**

How many per day? _____

On average how many days per week do you drink beer, wine, or other alcoholic beverages? _____

Exercise: Do you exercise beyond normal daily activities? _____ **Yes** _____ **No**

Describe the exercise: _____

On average how many days per week do you exercise or do physical activity? _____
For how many minutes per day? _____

Family History:

___ Arthritis _____ Relationship _____ Age

___ Cancer _____ Relationship _____ Age

___ Diabetes _____ Relationship _____ Age

___ Heart Disease _____ Relationship _____ Age

___ Hypertension _____ Relationship _____ Age

___ Osteoporosis _____ Relationship _____ Age

___ Psychological _____ Relationship _____ Age

___ Stroke _____ Relationship _____ Age

___Other _____

Past Medical History: Please check all that apply.

Infection/Disease:

___ Bone infection

___ Abscess

___ Hepatitis (B,C)

___HIV/AIDS

___Lymes

___Recent fever, chills, night sweats

___Other _____

_____

Cancer: (Affected tissue and dates)

_____

_____

Hormone:

___ Hyperthyroid

___ Hypothyroid

___ Osteoporosis

___ Other _____

_____

Lung:

___ Asthma

___ TB

___ Pneumothorax

___Pulmonary

___Hypertension

___Pulm. Embolus

___ Chronic Cough

___ Shortness of breath

___Other _____

_____

Blood Vessels:

___ Deep Vein Thrombosis

___ Arteriosclerosis

___ Bypass Surgery

___ Anemia

___ Hypertension

___ Other _____

_____

Heart:

___ Heart Attack

___ Stroke

___ Pacemaker

___ Valve Disorder

___ Arrhythmia

___ Congestive Heart Failure

___ Cardiac Hypertrophy

___ Heart Transplant

___ Other _____

_____

Gastrointestinal:

___ Ulcer

___ Appendectomy

___ Gall Bladder

___ Colitis

___ Crohns

___ Other _____

_____

Kidney:

___ Kidney Stones

___ Loss of Control

___ Urinary Tract Infection

___ Other _____

_____

Reproductive:

Men:

___ Prostate Surgery

___ Hernia

___ Other _____

_____

Women:

___ Pregnant

Due Date _____

___ Other _____

_____

Diabetes:

___ Type 1

___ Type 2

___ Insulin

Neurologic:

___ Seizures

___ MS

___ ALS

___ Guillain-Barre

___ Other _____

_____

Skin:

___ Cellulitis

___ Psoriasis

___ Scleroderma

Orthopedic:

___ Fractures

___ Dislocations

___ Surgery _____

_____

_____

Notes: