Admission Record

Form Completion Instructions:

Please answer all fields (Please enter N/A if not applicable). All information will remain strictly confidential. Questions, please ask our office associate.

Client Name:			Client Date of Birth	Social Security Number __ __ __ - __ __ - __ __ __ __
Mailing Address (No. & Street, Apt., etc.)			E-Mail Address (Required)	
City	State	Zip Code	Cell Phone Number ( )	
Home Phone Number ( )	Work Phone Number ( )		Preferred Phone Contact ☐ Cell ☐ Home ☐ Work	
Primary Insurance Carrier Name			Secondary Insurance Carrier Name	
Insured's relationship to you ☐ Self ☐ Parent ☐ Spouse ☐ Other			Insured's Name (Who carries insurance contract)	
Insured's Employer Name:			Insured's Employer Address:	
City	State	Zip	Employer Phone Number:	
Insured's Date Of Birth:			Emergency Contact and Phone	
Is this injury from a Motor Vehicle Accident? ☐ Yes ☐ No			Is this injury from a Workman's Comp. Claim? ☐ Yes ☐ No	
If yes, what is the name of the claims adjuster?			If yes, what is the phone number of the claims adjuster?	
If yes, what is the claim number?			If yes, what is the date of injury?	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed			Your occupation:	
Spouses Name:			Spouses Date of Birth	Social Security Number
PRIMARY CARE Physician Name			Phone Number	Date of Next Office Visit
REFERRING Physician Name (If any)			Phone Number	Date of Next Office Visit

Select all that apply: *"I'm coming to Borja Physical Therapy now because of..."*

☐ Friend/Family Member	☐ Online Search	☐ Valpak	☐ Radio	☐ Report
☐ My Doctor/Health Provider	☐ Facebook	☐ Google	☐ Newsletter	☐ Workshop
☐ My Insurance Website	☐ Newspaper	☐ Local Network	☐ Saw Sign	☐ Other:

Client Authorization And Responsibility

I hereby consent to treatment at Borja Physical Therapy PLLC. By consenting to treatment I authorize, on behalf of any covered family member or myself, direct billing of my insurance company and direct payment to Borja Physical Therapy PLLC. By consenting to treatment, I also consent to the release of necessary medical

information needed for the processing of the insurance claims, including release to any entity for the continuation of my medical care. I understand that a photocopy of the release is as valid as the original. In the event that my insurance company does not pay or partially pays on behalf of any covered family member or myself, I understand that it is my financial responsibility to remit payment in full to Borja Physical Therapy PLLC upon completion of the treatment sessions or within 30 days thereafter. I further understand that if the matter is referred to an attorney for collection, I will be responsible for the attorney's fees and court costs.

Signature of Client/Guardian/Parent	**Date**

Missed Appointments Policy

Borja Physical Therapy must receive 24-hour advance notice for cancelled appointments. Clients who do not provide 24-hour notice for their cancellation will be responsible for a $15.00 cancellation charge. Clients who do provide 24-hour notice for their cancellation will not be charged a cancellation fee. Clients who fail to cancel and fail to attend a scheduled appointment will be responsible for a $25.00 charge. These charges cannot be billed to insurance and must be paid on or before the next scheduled appointment. After two cancellations, we reserve the right to require same day appointment reservations or discharge from therapy services altogether with non-compliance documentation.

Signature of Client/Guardian/Parent	**Date**

Notice Of Privacy Practices

I hereby authorize that I am aware of my rights as it pertains to HIPAA and my Protected Health Information (PHI). Borja Physical Therapy has offered me a copy of their Notice of Privacy Practice for my own records. You may see our privacy practices at: borjapt.com/privacy-notice/ or request a copy from our Customer Service associate.

Signature of Client/Guardian/Parent	**Date**

Financial Policy

We are pleased and honored that you and/or your referring physician have trusted us with your care. We hope that after your first visit you will feel valued and well taken care of. Physical Therapy is a tool, a pathway to get you to your goals. Our highly trained staff members at Borja Physical Therapy strive to do their best to make your experience pleasant. As part of this relationship, we wish to review expectations of your financial responsibility as outlined in our Financial Policy.

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY

- **Insurance benefits are checked by the Borja Physical Therapy Billing Department as a courtesy to the patient.** Please provide insurance cards upon first visit to ensure that claims are submitted promptly. If you cannot pay upfront, the billing department may be able to work with you to set up a payment plan. In the rare case the insurance denies claims because information needs to be verified by you, the balance will be shifted to you until the issue is resolved with your insurance company. If you are unwilling to call the insurance company to give that required information, you will be responsible for the entire amount of the bill.

- If you have previously received services from the provider (Borja PT) and wish to return to physical therapy and **still have a remaining balance on file, you must pay off the remaining balance in full or enter into a payment plan agreement with the provider (Borja PT)** in order to begin treatment. As previously stated, the Borja PT Billing Department may work with you to create a payment plan based on the remaining balance in question.

- It is important to understand that **the patient is under contract with their own insurance company.** The amount owed to the provider (Borja PT) is 100% determined by the patient's policy. **The amount owed to the provider (Borja PT) is never determined by Borja PT.** This includes unmet deductibles, co-pays, or co-insurances. In general, it is not acceptable for a patient not to pay the amount owed to the provider (Borja PT) because it is a breach of the contract with the patient's insurance company. In addition, Borja PT is in contract (in network) with most insurance companies and therefore, where applicable, will write off anything over what is allowable by contract. Billing is done on a daily basis to all insurance companies.

- **Please do not ask the billing department to adjust off any charges, deductibles or co-pays over what is allowed by insurance as it is generally not permitted for them to do so.** It is VERY important for the patient to take responsibility in knowing his/her individual benefits and what insurance will allow so unexpected balances do not occur. **The Borja PT Billing Department files with many insurances and most offer several different plans, therefore it is the patient who must make sure the benefits checked are what match their plan.**

- In the case the patient needs a service that is not covered by the in network agreement, Borja PT will notify the patient to see if the patient agrees to the service. The billing department will then make arrangements to charge and bill the patient accordingly.

- If you do not have In-Network Medical Insurance, please speak with our billing coordinator to discuss self-pay options. **Please note: There is no payment plan option for our self-pay patients.**

- **Third Party/Workers Comp/MVA Patients:** We are happy to see personal injury or motor vehicle accident patients. The billing department will need information such as claim number, adjuster's name and contact phone number and mailing address. Should the Third Party/Workers Comp or MVA company deny our claims; the claims will be submitted to your Medical Insurance or become your responsibility. **Please let us know if you have an attorney involved along with his/her name and phone number.**

- **Minors and Dependents:** Parents and guardians are responsible for payment for their dependents at the time service is rendered.

- Billing statements are sent to patients with a personal balance on a monthly basis. We ask that upon receipt of such statement, payment is sent to our office within thirty (30) days of receipt. If you have a financial hardship or you are unable to pay the balance in its entirety, please contact our billing coordinator to discuss payment options. **If your account becomes delinquent and you have not established or met payment options with our billing office, your account will be turned over to our outside collection agency and your account will be assessed a $25.00 collection fee.**

We look forward to providing you with world class physical therapy services!!
Signing below indicates you understand and agree to the terms of this policy.

Signature of Client/Guardian/Parent _____ Date _____

No-Show / Cancellation Policy

Please Read Carefully

We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable, however, advance notification allows us to fulfill other clients scheduling needs and keeps the clinic operating at its most efficient level. We strive to promote a higher quality of care at Borja PT, and as such, missed, or late appointments are a significant disruption to the clinic, your physical therapist and other patients.

1. Please provide our office with 24-hour notice to change or cancel an appointment. Clients who do not provide 24-hour notice to change a scheduled appointment may be responsible for a $15.00 cancellation charge. Clients who do not attend a scheduled appointment may be responsible for a $25.00 no call/no show charge. These charges cannot be billed to insurance and must be paid on or before the next scheduled appointment.
2. We reserve your appointment time just for you. We do not double-book our clients so that we may provide optimum treatment outcomes. The 24-hour notice allows us to place another client in your canceled appointment period.
3. Your treatment plan has been established by you and your practitioners to help you to get you back to your regular activities as quickly as possible. Missing appointments hinders that process and may end up prolonging recovery.
4. Certain accident claims adjusters and application for disability will require regular attendance to physical therapy as a requirement of an approved treatment plan. If appointments are missed or canceled on a regular basis it could affect the status of your claim.
5. After missing two appointments without notice, you may be placed on a same day scheduling policy for your treatments, which would not allow you to schedule any appointments in advance.

Thank you for providing our office and our patients with this courtesy. Signing below indicates you understand and agree to the terms of this policy.

Signature of Client/Guardian/Parent _____ Date _____

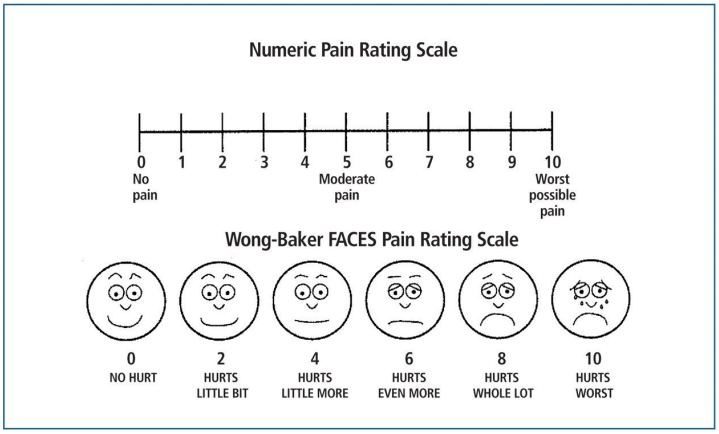
Medical History Information

Your Name _____ Your Age: _____

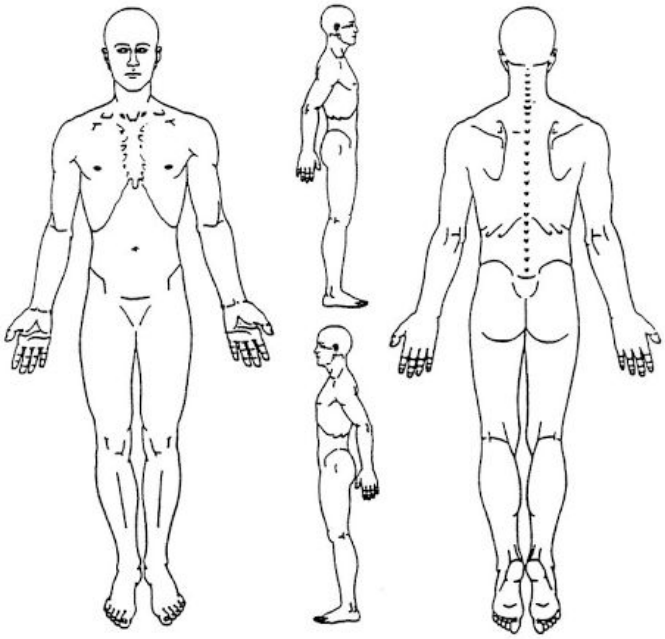
Use this chart to help you describe your particular level of pain to your health care provider.

☐ I have no pain ☐ Pinching ☐ Throbbing
☐ Stabbing ☐ Burning ☐ Persistent
☐ Dull ☐ Steady ☐ Comes & goes
☐ Aching ☐ Localized ☐ Pinching
☐ Other (please describe) _____

Use the chart below to assess your pain level:



Please shade or circle the areas where you are experiencing pain.



My pain at it's worst is:

0 1 2 3 4 5 6 7 8 9 10
(Circle one)

My pain on average is:

0 1 2 3 4 5 6 7 8 9 10
(Circle one)

1. What was the specific cause of injury, or the series of events leading up to your visit today?

Description: _____

_____

2. When were you injured? _____. Was your pain ☐ **Sudden** or ☐ **Gradual**?

3. Was your injury: ☐ Sudden or ☐ Gradual?

4. Medical History: Select all that apply to you. Have you been diagnosed with the following:

Arthritis/Osteoarthritis?	☐ Yes ☐ No	Diabetes Type 1?	☐ Yes ☐ No
Rheumatoid Arthritis?	☐ Yes ☐ No	Diabetes Type 2?	☐ Yes ☐ No
Osteoporosis?	☐ Yes ☐ No	Obese?	☐ Yes ☐ No
High blood pressure?	☐ Yes ☐ No	Seizures?	☐ Yes ☐ No
Heart/circulation disorders?	☐ Yes ☐ No	Dizzy Spells?	☐ Yes ☐ No
Immune deficiency disease?	☐ Yes ☐ No	History of Cancer?	☐ Yes ☐ No
History of falling?	☐ Yes ☐ No	Currently pregnant?	☐ Yes ☐ No
Hard of hearing?	☐ Yes ☐ No	Vision Difficulty?	☐ Yes ☐ No

Explain / Other not listed:

_____

_____

5. Imaging: Check all imaging performed for your condition:

☐ X-ray ☐ MRI ☐ CT Scan ☐ Other: _____ When?

_____

What were the results? _____

6. Surgery: Please list any and all surgeries you have had at or near your injury site and include year performed.

_____

7. **List medications you are taking now:** If you brought a list, we can make a copy. If no list today, please list below. We cannot see you without a list of medications today. Please include name, dosage and frequency.

_____

_____

8. List any allergies you have: _____

Name of person completing this form (print)	Signature of Client or Responsible Adult and Date

---

Do NOT complete this section. This section to be completed by your physical therapy clinician.

Clinical Notes

ROM:			
Flexion:	_____°	Flexion:	_____°
Extension:	_____°	Extension:	_____°
Abduction:	_____°	Abduction:	_____°
Internal Rotation:	_____°	Internal Rotation:	_____°
External Rotation:	_____°	External Rotation:	_____°
Side Bend R:	_____°	Side Bend R:	_____°
Side Bend L:	_____°	Side Bend L:	_____°
Rotation R:	_____°	Rotation R:	_____°
Rotation L:	_____°	Rotation L:	_____°
MMT:			
Flexion:	_____ /5	Flexion:	_____ /5
Extension:	_____ /5	Extension:	_____ /5
Abduction:	_____ /5	Abduction:	_____ /5
Internal Rotation:	_____ /5	Internal Rotation:	_____ /5
External Rotation:	_____ /5	External Rotation:	_____ /5
Side Bend R:	_____ /5	Side Bend R:	_____ /5
Side Bend L:	_____ /5	Side Bend L:	_____ /5
Rotation R:	_____ /5	Rotation R:	_____ /5
Rotation L:	_____ /5	Rotation L:	_____ /5

Pain increases with: ☐ Passive ☐ Active ☐ Flexion ☐ Extension ☐ Rot. R ☐ Rot. L ☐ Other:

_____

Pain decreases with: ☐ Passive ☐ Active ☐ Flexion ☐ Extension ☐ Rot. R ☐ Rot. L ☐ Other:

_____

Special Testing

(+)(-)	(+)(-)	(+)(-)	(+)(-)

☐☐ SLR
☐☐ Fabers
☐☐ Piriformis sign
☐☐ Slump test
☐☐ Instability test

☐☐ Hip IR test
☐☐ Thomas test
☐☐ Patellar Tracking
☐☐ Excessive Q angle
☐☐ IT band syndrome

☐☐ Thessaly's Test
☐☐ ACL/PCL/MCL/LCL
☐☐ Lat Jt line
☐☐ Medial Jt line
☐☐ _____

☐☐ Hawkins-Kenney
☐☐ Impingement
☐☐ Biceps load test
☐☐ A/C compression
☐☐ _____