Arizona

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Patient Medical History Form

Patient Name _____

Age _____ Height _____ Weight _____

Area of Injury or Pain _____

Date symptoms began _____ Date of last doctor appointment _____ Date of follow-up _____

What other treatment have you received for this problem? _____

_____

What diagnostic tests have been done for this condition? □ X-Ray □CT Scan □MRI □EMG □Other

List all medications you are currently taking _____

_____

List any allergies you have _____

List all major surgeries you have had _____

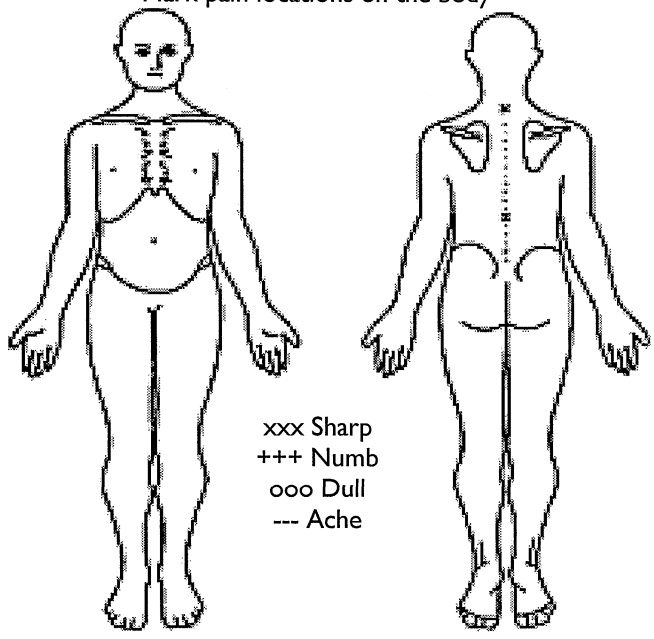
Have you fallen in the last year? _____ If yes, explain _____

Have you ever had physical therapy before? _____ If yes, when? _____ Reason _____

Are you currently or have you ever been treated for any of the following:

- □ High Blood Pressure
- □ Pacemaker
- □ Breathing Conditions
- □ Heart Conditions
- □ Stroke/CVA
- □ High Cholesterol
- □ Seizures
- □ Dizziness
- □ Cancer
- □ Osteoporosis
- □ Headaches
- □ Depression
- □ Fractures
- □ Chance of/Current Pregnancy
- □ Skin Sensitivity
- □ Diabetes
- □ Other: _____

Mark pain locations on the body



xxx Sharp
+++ Numb
ooo Dull
--- Ache

List 3 specific things you have difficulty performing due to your symptoms: (Examples are dressing, doing dishes, housework, playing sports, gardening, playing with or lifting your children, specific work duties, sitting or standing for more than 10 minutes, unable to walk for more than 20 minutes)

1. _____
2. _____
3. _____

List your goals for treatment: _____

_____

Exercise/activity level prior to injury: ____ 0 days/week ____ 1-2 days/week _____ 3-5 days/week ____ 6-7days/week

What types of activities? _____

_____ _____

Patient Signature Date

_____ _____

Therapist Signature Date

Pain Disability Index

Pain Disability Index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family/Home Responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school).

No Disability 0 1 2 3 4 5 6 7 8 9 10 **Worst Disability**

Recreation: This disability includes hobbies, sports, and other similar leisure time activities.

No Disability 0 1 2 3 4 5 6 7 8 9 10 **Worst Disability**

Social Activity: This category refers to activities which involve participation with friends and acquaintances, other than family members. It includes parties, theater, concerts, dining out, and other social functions.

No Disability 0 1 2 3 4 5 6 7 8 9 10 **Worst Disability**

Occupation: This category refers to activities that are part of or directly related to one's job. This includes non-paying jobs as well, such as that of a housewife or volunteer.

No Disability 0 1 2 3 4 5 6 7 8 9 10 **Worst Disability**

Sexual Behavior: This category refers to the frequency and quality of one's sex life.

No Disability 0 1 2 3 4 5 6 7 8 9 10 **Worst Disability**

Self Care: This category includes activities, which involve personal maintenance and independent daily living (e/g/ taking a shower, driving, getting dressed, etc.)

No Disability 0 1 2 3 4 5 6 7 8 9 10 **Worst Disability**

Life-Support Activities: This category refers to basic life supporting behaviors such as eating, sleeping, and breathing.

No Disability 0 1 2 3 4 5 6 7 8 9 10 **Worst Disability**

Signature _____ **Please Print** _____

Date _____

References: Pollard CA. Preliminary validity study of the pain disability index. *Percept Mot Skills.*1984;59(3):974.

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Patient Information Sheet

Patient Information

Patient Name _____

Address _____

City _____ State _____ Zip_____

Home Phone ( ) _____

Cell Phone ( ) _____

Social Security Number _____

Birth Date _____Male/Female _____

Contact Name_____

Contact Number ( ) _____

Relationship _____Marital Status_____

Are You Employed? Yes □ No □

Employer Name _____

Address_____

City_____ State_____ Zip_____

Work Phone ( ) _____

Primary Physician_____

Primary Physician Phone # ( ) _____

Referring Physician_____

Referring Physician Phone # ( )_____

How did you hear about us? _____

Health Insurance – Primary (Please provide insurance card and driver's license to be copied)

Insurance Co _____
Name of Insured _____
Insured SS# _____
Insured DOB _____

Policy # _____
Group # _____
Benefits Pone # _____

Health Insurance – Secondary

Insurance Co _____
Name of Insured _____
Insured SS# _____
Insured DOB _____

Policy # _____
Group # _____
Benefits Pone # _____

Workers' Compensation Information

Is this a work related injury? Yes □ No □
Are you currently working? Yes □ No □
Employer _____
Employer's Address _____
City _____ State _____ Zip_____
Contact _____
Phone ( )_____
Injury Date _____

Worker's Compensation Insurance Carrier_____
_____
Address _____
City _____ State _____ Zip _____
Contact _____
Phone ( ) _____
Claim # _____

WAS THIS A MOTOR VEHICLE ACCIDENT? YES____NO____

Release of Information

I give permission to Arizona Sports Physical Therapy to release information to my insurance company, attorney, assignees and/or beneficiaries.

Assignment of Benefits

I authorize payment directly to Arizona Sports Physical Therapy for services I receive.

Payment Guarantee

In consideration of the services rendered and to be rendered to the above named patient by Arizona Sports Physical Therapy, I expressly guarantee payment of this account and agree to pay any charges left unpaid in whole or in part by the insurance company. Patient is ultimately responsible for account totals and balances. If your patient account balance becomes delinquent for more than 90 days we reserve the right to charge a $20 late fee and or send the account to a third party collection agency.

X_____ _____

Signature of Patient or person responsible for Patient Date

Patient Policies

Insurance Billing

We will gladly call your insurance company to identify your current benefit coverage. Please understand, however, that insurance companies will not guarantee medical benefits over the phone. The information provided is used only as an estimate. Actual determination is made only after we receive the written notification and/or payment on your claims. We strongly encourage you to contact your insurance company directly in order to understand your plan's coverage and limitations. Please note that we will bill up to two (2) insurance companies, primary and secondary, for MEDICARE related claims and only one (1) insurance company, primary, for all other claims, unless prior agreements have been made with our Office Manager.

Prescriptions and Progress Reports

Your insurance company may also require a current physical therapy prescription (prescriptions expire 30 days from the date they are written), a "Letter of Medical Necessity" written by your physician and/or pre-authorization directly from your physician for therapy services. This is your responsibility to obtain and non-compliance with this may result in services not being reimbursed by your insurance company. With that, it is extremely important to keep us informed of your follow-up visits with physician. Informing us at least three (3) days before your appointment, the therapist will have time to write a progress report to your physician. This progress report, once signed by the doctor and brought back to Arizona Sports Physical Therapy, often times serves as the prescription for further therapy.

Payments

Once we have received all payments or notifications from your insurance company, we will present you with your final statement. Payment for any outstanding balance will be due in full no later than 30 days from the date of your final statement.

Consent to Treat

I understand that I have been referred for physical therapy treatment to Arizona Sports Physical Therapy. I understand that I have the right to ask any questions and have any questions answered prior to receiving any treatment, including any risks or alternatives to the treatment plan that has been prescribed by my physician and/or by my therapist. By signing this agreement, I consent to have Arizona Sports Physical Therapy provide treatment and care as prescribed by my physician and/or recommended by my therapist. ASPT is a teaching facility. During your treatment, you may receive care from a supervised student.

Acknowledgement of Cancellation Policy

All patients are required to provide notice if you are not able to attend a scheduled appointment. Missed or recurrent cancelled appointments without adequate notice will be subject to a $25 (twenty five dollar) fee. This fee is NOT covered by your insurance company and is the responsibility of the patient. If no-show or same day cancellations occur on a continual basis it is regretful that therapy be discontinued. If you anticipate being late, please call to let us know.

_____ _____

Patient or Guardian Signature Date

_____

Patient Printed Name

The HIPAA privacy rule gives individuals the right to request restriction on uses and disclosures of private health information (PHI). The individual is also provided the right to request confidential communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead.

Patient Record of Disclosures
I wish to be contacted in the following manner (check all that apply)

Home Telephone _____
- ☐ Leave message with call-back number only
- ☐ O.K to leave message with detailed information

Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office
- ☐ O.K. to fax to this number

Email/Other _____
_____
_____

Attorney: _____

_____ _____ _____
Patient Signature Date Print Name Legibly

Acknowledgement of Receipt of Notice of Privacy Practices

Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under HIPAA< providers of healthcare are required to give patients their Notice of Privacy Practices of Protected Health Information and make a good faith effort to obtain written acknowledgement that this notice was received.

Therefore, I acknowledge that Arizona Sports Physical Therapy has provided a written copy of its Notice of Privacy Practices of Protected Health Information to ❑ myself or ❑specify: _____

_____ _____ _____
Signature of Patient or Guardian Date Print Name and Relationship