ARIZONA MANUAL THERAPY CENTERS

Thank you for choosing ARIZONA MANUAL THERAPY CENTERS. Please read each section below carefully, sign and date, and return to the front office personnel. If you have any questions or concerns, please ask us and we will be happy to assist.

AUTHORIZATION FOR TREATMENT

All procedures will be thoroughly explained to you before they are performed. There are certain risks with Physical Therapy treatment because you will be asked to exert effort and perform activities with increasing degrees of difficulty, which could cause an increase in your current level of pain or discomfort or aggravation to your existing injury. There is also a possibility that you could experience a new injury, but this risk is small. You will be able to control any procedure by stopping if you feel any increase in pain or discomfort. The Physical Therapist and/or Physical Therapist's Assistant will take every precaution to ensure that you are protected from any hazardous situation. You will never be forced to perform any procedure that you do not wish to perform. Based on the above information I agree to cooperate fully and to participate in all Physical Therapy procedures and to comply with the plan of care as it is established. **NOTICE TO PATIENTS**: For your safety, do not use any equipment without a staff member present. **Initial** _____

NOTICE OF INFORMATION PRACTICES

I have read and fully understand Arizona Manual Therapy Centers' Notice of Information Practices. I understand that Arizona Manual Therapy Centers may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Arizona Manual Therapy Centers will consider the requests for restrictions on a case by case basis, but does not have to agree to requests for restrictions. I authorize the use and disclosure of my personal health information for purposes as noted in Arizona Manual Therapy Centers' Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time. **Initial** _____

DESIGNATED INDIVIDUALS AUTHORIZATION

I authorize the following designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information. (must be completed or we will be unable to speak with anyone but yourself regarding your care, including appointments, bills, therapy services) ❒ **Speak only with myself**

Name	Relationship	Name	Relationship
_____	_____	_____	_____

PATIENT INFORMATION CONSENT *(OPTIONAL)*

I authorize Arizona Manual Therapy Centers to use my protected health information for targeted marketing, fundraising and/or solicitation of participation in research studies. I understand that I have the right to copy or inspect any information used for these purposes. I also understand that this authorization does not affect my consent to use my protected health information for treatment, billing or operations related to treatment and billing. **Initial** _____ (optional)

~~~~~~ALL PATIENTS SIGN BELOW~~~~~~

I have read and understand the above information.

_____		_____
Patient Name	**OR**	Legal Guardian Name
_____		_____
Patient Signature		Legal Guardian Signature
Date: _____		Date:_____

ARIZONA MANUAL THERAPY CENTERS

PATIENT INFORMATION

Today's Date:_____

Name(Legal Name, First/ MI/ Last):_____

Date of Birth:_____ **SS #:**_____

Prefer to be called:_____ **When did symptoms first occur?**_____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Legally Separated** ☐ **Widowed** **Sex:** ☐ **Female** ☐ **Male**

Address (Street):_____ **Apt/ Unit:** _____

City:_____ **State:**_____ **Zip:**_____

Is this a permanent address? ☐ **Yes** ☐ **No** *If No, What is permanent address?*

Permanent address:_____

Home Phone:_____ **Work Phone:**_____ **Cell Phone:**_____

Cell Phone Provider:_____

RESPONSIBLE PARTY ❒ Same as Patient

Responsible Party:_____ **DOB:**_____

Address:_____ **or ❒ Same as Patient**

Responsible Party Phone #:_____ **or ❒ Same as Patient**

Patient Employer:_____ **❒ I am retired**

EMERGENCY CONTACT

Emergency Contact Name:_____ **Phone:** _____

Relationship to Contact:_____

INSURANCE INFORMATION

Primary Insurance:_____

Subscriber & Relationship:_____Subscriber Date of Birth:_____

Policy/ ID #:_____ Group #/ Name:_____

Secondary Insurance:_____

Subscriber & Relationship:_____ Subscriber Date of Birth:_____

Policy/ ID #:_____ Group #/ Name:_____

INJURY OR WORK-RELATED INFORMATION

Insurance Carrier:_____

Claim #:_____ **Claim's Adjustor:**_____

Date of Injury:_____ **State:**_____**Adjustor's Phone:**_____

How did injury happen?_____

ARIZONA MANUAL THERAPY CENTERS

Patient Name:_____ Date of Birth:_____

CONFIRMATION/ EMAIL INFORMATION

How would you like to have appointments confirmed? Please indicate: ☐TEXT ☐EMAIL ☐Call Home ☐Call Cell
Email: (*For internal use only*)_____@_____

REFERRAL INFORMATION

Referred by:_____
Primary Care Physician, if different:_____

Height:_____ Weight:_____

Medication List (please list all current medications, including prescriptions, supplements, herbs, over-the counter, etc)

Medication Name	Why do you take it?	Strength	Frequency/ How often (how many times a day/week) do you take it	How is it Administered (how do you take it? Pill/injectable…)
☐ SEE ATTACHED LIST				

RELEASE OF INFORMATION & AUTHORIZATION OF BENEFITS

Patient or Guardian Agreement:

- _____(Initial) I certify that the above information is accurate and true to the best of my knowledge.
  _____(Initial) I authorize release of information requested by my insurance plan for payment. I assign benefit of payment to Arizona Manual Therapy Centers by my insurance carrier(s). I understand that I am financially responsible for any unpaid balances.
- _____(Initial) I agree to comply with the terms and conditions as outlined in the Patient Registration form.

Signature of Patient or Guardian:_____ Date _____

Relationship:_____

ARIZONA MANUAL THERAPY CENTERS

Patient Name:_____ Date of Birth:_____

MEDICARE PATIENTS ONLY

Are you <u>currently</u> receiving Home Health Care? ☐**YES** ☐**NO. If yes,** please provide the name & phone number of the agency:_____

Have you had Physical Therapy or Occupational Therapy this calendar year? ☐**YES** ☐**NO.** If yes, please provide the name & phone number of the clinic. Were you discharged from their care?

_____

If you are a Medicare patient, it is mandatory that we have all of the following information on file.

MEDICARE PATIENTS ONLY

- Have you fallen in the past year? ☐ Yes ☐ No
- Have you had 2 or more falls in the past year? ☐ Yes ☐ No
- Did you sustain any injury from a fall? ☐ Yes ☐ No

Patient Responsibilities at Arizona Manual Therapy Centers

Please read and initial each of the following. Sign and date at the bottom.

- I understand that it is my responsibility to know my insurance benefits and policy requirements for all physical therapy services. _____(Initial)
- I understand that it is my responsibility to provide Arizona Manual Therapy Centers with my current insurance information or other method of payment for each visit or service provided. _____(Initial)
- I understand that it is my responsibility to provide a current therapy prescription and/or referral prior to services being rendered. Failure to do so could result in denial by my insurance carrier and all charges will become my responsibility. _____(Initial)
- I understand that failure to update my insurance information, current address and contact information may cause me to become responsible for charges. _____(Initial)
- I understand that it is my responsibility to inform the front desk AND therapist if I have been seen at another clinic for physical therapy, occupational therapy, or speech therapy. _____(Initial)
- I understand that it is my responsibility to provide a prior authorization (if required by my insurance) or letter of medical necessity (if required) from my physician prior to treatment. _____(Initial)
- I understand that it is my responsibility to inform the front desk AND the therapist if my treatment is the result of an injury related to an auto accident, work injury, or school injury. _____(Initial)
- It is my responsibility to notify Arizona Manual Therapy Centers 24 hours in advance if I am unable to keep my scheduled appointment. Failure to do so may result in a $50 no-show/ cancellation fee, which must be paid prior to scheduling my next appointment. _____(Initial)
- Payment is due at the time of service. I am responsible for any collection fees and interest allowed by law that may be added to my account. I understand if I have an unpaid balance to Arizona Manual Therapy Centers and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts. _____(Initial)
- In order for Arizona Manual Therapy Centers or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Arizona Manual Therapy Centers and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable. _____(Initial)
- I understand that if my account has been forwarded to an outside collection agency, I may not return to Arizona Manual Therapy Centers until I have my previous account has been paid in full and payment arrangements have been made for future services. _____(Initial)

I have read the above and understand my responsibilities as a patient of Arizona Manual Therapy Centers. I have had the opportunity to ask questions and have them answered to my satisfaction. My signature below indicates my acceptance of these terms.

_____ _____

Patient Name (PLEASE PRINT) Date

_____

Patient or Legal Guardian/ Representative's Signature

Patient#_____ Provider_____

PHYSICAL THERAPY INITIAL EVALUATION FORM

PATIENT INFORMATION DATE_____

NAME_____ OCCUPATION_____
(LAST) (FIRST)

BIRTHDATE_____ AGE_____ HEIGHT_____ WEIGHT_____lbs

HOME/CELL PHONE_____ EMPLOYER_____

REHAB INFORMATION

1. CHIEF COMPLAINT/AILMENT/INJURY_____

2. DATE OF INJURY_____ DATE OF SURGERY_____

3. BRIEFLY DESCRIBE HOW YOU WERE INJURED

_____

_____

4. HAVE YOU RECEIVED THERAPY FOR THIS CONDITION? ○ YES ○ NO WHEN?_____

HOW MANY VISITS?_____

5. HAS YOUR CONDITION BEEN GETTING: ○ WORSE ○ SAME ○ BETTER

6. ARE YOUR SYMPTOMS: ○ CONSTANT OR ○ INTERMITTENT

7. MARK THE NUMBER THAT BEST CORRESPONDS TO YOUR PAIN:

AT BEST: ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 (EXCRUCIATING PAIN)

AT WORST: ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 (EXCRUCIATING PAIN)

8. WHAT INCREASES/MAKES YOUR CONDITION WORSE? (MARK ALL THAT APPLY)

☐ BENDING	☐ MOVEMENT	☐ REST	☐ SNEEZE
☐ SITTING	☐ STANDING	☐ STAIRS	☐ DEEP BREATH
☐ RISING	☐ WALKING	☐ COUGH	☐ MEDICATION
☐ PROLONGED POSITIONING	☐ LYING	☐ WORSE IN AM	☐ WORSE IN PM
☐ WORSE AS DAY PROGRESSES	☐ N/A CAST JUST REMOVED		

9. WHAT DECREASES/MAKES YOUR CONDITION BETTER? (MARK ALL THAT APPLY)

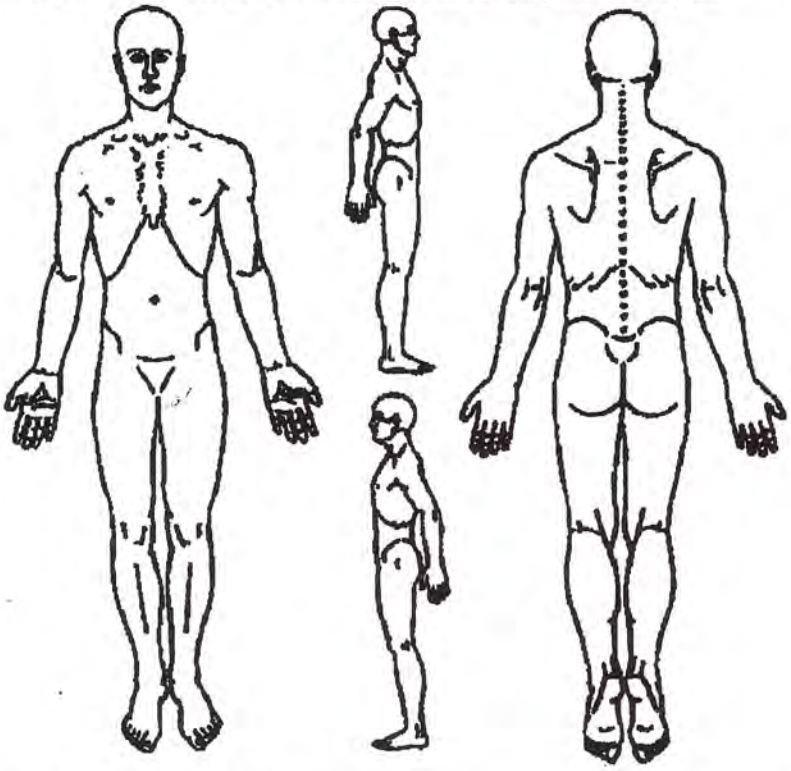
☐ BENDING	☐ MOVEMENT	☐ REST	☐ BETTER IN AM
☐ SITTING	☐ STANDING	☐ HEAT	☐ BETTER AS DAY PROGRESSES
☐ RISING	☐ WALKING	☐ ICE	☐ BETTER IN PM
☐ CHANGING POSITIONS	☐ LYING	☐ MEDICATION	☐ N/A CAST JUST REMOVED

10. PREVIOUS MEDICAL INTERVENTION (MARK ALL THAT APPLY)

☐ X-RAY ☐ MRI ☐ CATSCAN ☐ INJECTIONS OTHER_____

Patient#_____ Provider_____

DRAW IN AREAS OF PAIN ON BODY DIAGRAMS USING APPROPRIATE SYMBOLS. If you are completing this form on the computer, print form after completion and mark the diagram with a pen.



SEVERE PAIN	*******
MODERATE PAIN	00000000
DULL ACHE	∩∩∩∩∩∩
RADIATING PAIN	↑↓↑↓↑↓↑↓
NUMBNESS/TINGLING	XXXXXX

DESCRIPTION OF PAIN (MARK ALL THAT APPLY)

- ☐ THROBBING
- ☐ SHARP
- ☐ SHOOTING
- ☐ SORE
- ☐ OTHER _____

11. WHAT ARE YOUR GOALS TO BE ACHIEVED BY THE END OF THERAPY?

_____

_____

MEDICAL INFORMATION (MARK ALL THAT APPLY) **THIS INFORMATION IS CONFIDENTIAL AND REMAINS PART OF YOUR CHART

☐ DIFFICULTY SWALLOWING	☐ MOTION SICKNESS	☐ STROKE
☐ ARTHRITIS	☐ FEVER/CHILLS/SWEATS	☐ OSTEOPOROSIS
☐ HIGH BLOOD PRESSURE	☐ UNEXPLAINED WEIGHT LOSS	☐ ANEMIA
☐ HEART TROUBLE	☐ BLOOD CLOTS	☐ BLEEDING PROBLEMS
☐ PACEMAKER	☐ SHORTNESS OF BREATH	☐ HIV/HEPATITIS
☐ EPILEPSY/SEIZURES	☐ HISTORY OF SMOKING	☐ HISTORY OF ALCOHOL ABUSE
☐ HISTORY OF DRUG ABUSE	☐ DIABETES	☐ DEPRESSION/ANXIETY
☐ MYOFASCIAL PAIN	☐ FIBROMYALGIA	☐ PREGNANCY
☐ CANCER		

PREVIOUS SURGERIES:_____

OTHER:_____

MEDICATIONS:

_____

_____

ALLERGIES:_____

ARIZONA MANUAL THERAPY CENTERS
Sport • Spine
Orthopedic Rehabilitation

EFFECTIVE SEPTEMBER 11, 2017

Our busy season is upon us. We are asking all patients to be aware of office policy and help us be more effective in treating ALL patients.

- We require 24 hour cancellation. If patients do not show for appointments or provide less than 24 hour notice, there will be a $50 fee applied to your account. This fee must be paid prior to being treated at your next appointment. Emergencies happen and we will do our best to be understanding.

- Patients who are more than five minutes late may be asked to reschedule and charged a $50 late fee.

We allocate time to every patient and do our best to be respectful of your time and be ON TIME for you. We ask that you do the same for us and our other patients.

Patient Signature:_____ Date:_____

Arizona Manual Therapy Centers, PLLC

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