V _____

Patient Name: _____

Height: _____ft _____in Weight:_____ lbs Date of injury: _____

How did this injury/ exacerbation occur? _____

Have you been hospitalized for the present condition? □ Yes □ No If Yes, date: _____

Have you had surgery for the present condition? □ Yes □ No If Yes, date: _____

If yes, surgery type: _____

Have you had any falls this past year? □Yes □No If Yes, how many?_____

Have you received previous treatment for this condition? □ Yes □ No If Yes, date: _____

If yes, please summarize: _____

Are you currently working? □Yes □No If so, what is your job:_____

Please indicate your medical history below:

Acquired Respiratory Distress Syndrome	□Y	□N	Allergies	□Y	□N
Angina	□Y	□N	Headaches	□Y	□N
Anxiety or Panic Disorders	□Y	□N	Back Injury	□Y	□N
Arthritis (RA, OA)	□Y	□N	Bleeding Disorders	□Y	□N
Asthma	□Y	□N	Bladder Abnormalities	□Y	□N
Chronic Obstructive Pulmonary Disease	□Y	□N	Cancer	□Y	□N
Congestive Heart Failure	□Y	□N	Dizzy or Fainting Spells	□Y	□N
Degenerative Disc Disease	□Y	□N	Epilepsy or Seizure Disorder	□Y	□N
Depression	□Y	□N	Fracture	□Y	□N
Diabetes	□Y	□N	Hepatitis A, B, C, please circle type	□Y	□N
Emphysema	□Y	□N	Hernia	□Y	□N
Hearing Impairment	□Y	□N	High Blood Pressure	□Y	□N
Heart Attack	□Y	□N	Hypoglycemia	□Y	□N
Multiple Sclerosis	□Y	□N	Immunosuppressant Condition	□Y	□N
Osteoporosis	□Y	□N	Kidney Problems	□Y	□N
Parkinson's Disease	□Y	□N	Liver Dysfunction	□Y	□N
Stroke	□Y	□N	Metal Implants	□Y	□N
TIA	□Y	□N	Nausea	□Y	□N
Reflux	□Y	□N	Vomiting	□Y	□N
Visual Impairment	□Y	□N	Pacemaker	□Y	□N
Smoking	□Y	□N	Ringing in Your Ears	□Y	□N
Tuberculosis	□Y	□N	Peripheral Vascular Disease	□Y	□N
Special Diet Guidelines	□Y	□N	Skin Abnormalities	□Y	□N

Any other medical history:_____

Patient Name: _____

To help us understand your symptoms, please circle all that apply.

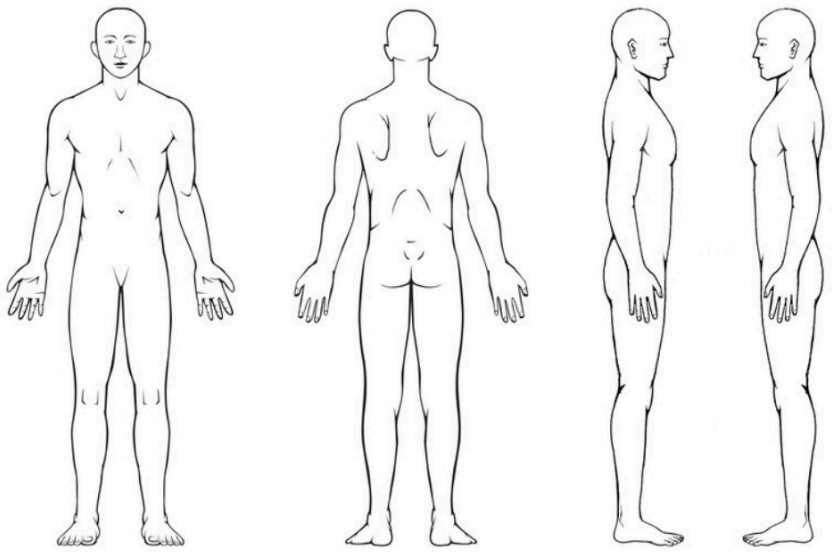
My pain is worse: in the morning/ during the day/ at night/ constant/ with activity/ during rest

On a scale of 0 to 10 (0 being no pain and 10 being unbearable pain requiring hospitalization)

Please rate your pain at its best _____ and at its worst_____

Pain Diagram

Using the key provided, please draw the symbol representing your pain over the area of the body as it relates to your present condition



Key

↑ or ↓ Radiating Pain

XXX Spasm

ZZZ Tenderness

//// Numbness/Tingling

000 Ache/Pain

Please list any current medications:

MEDICATION/SUPPLEMENT NAME	DOSAGE	TIMES PER DAY	ORAL, INJECTION...

Financial Policy

• **INSURANCE**- Your insurance policy is a contract between you and your insurance company. It is your responsibility to be aware of your insurance coverage, limitations, and terms and conditions. Verification of benefits are performed as a courtesy to you. Summit Physical Therapy AZ is not responsible for information that is obtained from your insurance carrier that is later deemed inaccurate. You are contractually responsible for your co-payment, co-insurance or any balance unpaid at the time of service. We accept Check, Visa, MasterCard, and Discovery.

• **NO INSURANCE**- Patients who are self-pay are responsible for the entire balance at the time of service. In certain cases alternative payment options may be considered.

• **REGARDING INSURANCE**- We will bill your insurance company upon receipt of your current insurance information. If your insurance company has not paid your account in full within 45 days, the balance may automatically be billed to you. Please be aware that some, and perhaps all, of the services provided may be non-covered services and are not considered reasonable and necessary under the Medicare Program and/or other medical insurance. Non-covered services will be billed to the patient.

• **MEDICARE MEDICAL NECESSITY**- Medicare will pay only for services that it determines to be "reasonable and necessary" under the Medicare laws. If Medicare determines that a particular service, although it would otherwise be covered, is not reasonable and necessary, Medicare will deny payment for that service. If Medicare denies payment, you are personally and fully responsible for payment.

• **RETURNED CHECKS**- There is a $25.00 fee if your check is returned unpaid. In addition, any future services will require cash or credit card payments.

• **STATEMENTS**- Charges shown on statements are agreed to be correct and reasonable unless protested in writing within 30 days of the billing date.

• **COLLECTIONS**- Should it be necessary to place your unpaid account with our outside collection agency, you must communicate directly with them. I have read, understand, and agree to abide by the financial policy of Summit Physical Therapy AZ.

•*** **NO-SHOW/LATE CANCELLATION- If you must cancel your appointment, you will be required to cancel 24 hours before your appointment time. "No-show" patients and cancellations with less than 24 hour notice may be charged a $25.00 fee. IF THIS OCCURS 3 OR MORE TIMES YOU MAY BE TERMINATED FROM THE PRACTICE.*****

x_____ _____

Signature of Patient/Patient Representative Date

Medicare Patients Only:

Have you had any therapy services elsewhere this year? (Circle one) Yes No

If you answered "Yes", have you been discharged? Yes No

Home Health:

Is anyone coming to your home to provide services at this time? Yes No

Consent for Communication

I understand that authorized personnel from Summit Physical Therapy AZ may communicate with me regarding scheduling, billing statements, and educational information including newsletters as it relates to health related products or services available at Summit Physical Therapy AZ or alternative treatments, locations, or providers.

Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to, or intercepted by unauthorized third parties. However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication.

▢ **I consent** and accept the risk in receiving information via email. I understand I can withdraw my consent at any time.

My email address is: _____

x_____ _____
Signature of Patient/Patient Representative Date

▢ **I do not consent** to receiving any information via email. I understand that I can change my mind and provide consent later.

x_____ _____
Signature of Patient/Patient Representative Date

Acknowledgement of Receipt of Privacy Practices

SUMMIT PHYSICAL THERAPY AZ

I, _____, am aware of Summit Physical Therapy AZ's Notice of Privacy Practices policies which went into effect on April 1st, 2018. I understand that I may request and receive a copy of these policies.

x_____ _____
Signature of Patient/Patient Representative Date

PATIENT INFORMATION CONSENT: I have read and fully understand Summit Physical Therapy AZ's Notice of Privacy Practices. I understand that Summit Physical Therapy AZ 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 by notifying the practice. I also understand that Summit Physical Therapy AZ will consider requests for restriction on a case by case basis, but do not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Summit Physical Therapy AZ's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

x_____ _____
Signature of Patient/Patient Representative Date

Consent for Treatment

I understand I have the right to choose my physical therapy provider and have chosen Summit Physical Therapy AZ and hereby authorize and give my consent for Summit Physical Therapy AZ to furnish physical therapy care and treatment deemed necessary or advisable in evaluating or treating my physical condition. I further understand no guarantees have been made to me as to the outcome of treatment.

x_____ _____
Signature of Patient/Patient Representative Date

IF PATIENT IS A MINOR: As parent and/or legal guardian, I authorize and give my consent for Summit Physical Therapy AZ to treat (minor's name) _____ while I am not present.

x_____ _____
Signature of Patient Representative Date