PATIENT INFORMATION

Date: _____

Last Name: _____ First: _____ MI: _____

Male: _____ Female: _____ DOB: _____ Age: _____

Billing Address: _____

Home Address: _____

Home#: _____ Work#: _____ Cell#: _____

Employer: _____ Occupation: _____

Referring Doctor: _____ Primary Care Physician (PCP): _____

How did you hear about us? _____

Complete if Patient is a Minor

Father/Guardian: _____ DOB: _____

Cell#: _____ Work#: _____

Mother/Guardian: _____ DOB: _____

Cell#: _____ Work#: _____

Spouse's Information

Name: _____ DOB: _____

Employer: _____ Occupation: _____ Contact#: _____

Emergency Contact Not Living with Patient

Emergency Contact: _____ Contact#: _____

RELEASE OF BENEFITS AND INFORMATION OF CONSENT TO TREATMENT: I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to PNW Physical Therapy all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I hereby authorize the clinic to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

I consent to treatment by the authorized personnel of PNW Physical Therapy as may be dictated by prudent medical practice by illness, injury, or condition. This consent is intended as a waiver of liability for such treatment except in acts of negligence.

Signed: _____ Date: _____

PATIENT HISTORY

Date:_____

Last Name:_____ First:_____ MI:_____

Gender: _____Male _____Female DOB:_____ Age:_____

OCCUPATION:_____

Have you missed any work or school due to your condition? _____Yes _____No

Date your condition/symptoms began?_____

Name of referring physician: _____

Did you have surgery? _____Yes _____No

If yes, what procedure was performed?_____on(date)_____

Please describe your condition or symptoms:_____

_____

Please rate your pain with activity: No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain

Location of pain: _____Right _____Left _____N/A

How would you describe your pain?

_____Burning	_____numbness	_____Tingling
_____Sharp	_____Throbbing	_____Constant
_____Dull/Achy	_____Shooting	_____Intermittent
_____Worse in AM	_____Worse in PM	_____Chronic

What eases symptoms?_____

What aggravates symptoms?_____

Have you ever had previous treatment for this condition? _____Yes _____No

What type of treatment and at what facility?_____

Was the previous treatment successful? _____Yes _____No

Have you had any X-Rays, MRIs, or other diagnostic procedures? _____Yes _____No

If known, what were the results of imaging?_____

PATIENT HISTORY

GENERAL MEDICAL INFORMATION:
Mark **Y** or **N** if you currently or have ever had any of the following conditions:

_____ Osteoarthritis	_____ High Blood Pressure	_____ Hepatitis
_____ Rheumatoid Arthritis	_____ Anemia	_____ Huntington's
_____ Allergies	_____ Cerebral Vascular Accident	_____ Fibromyalgia
_____ Cancer	_____ Cauda Equina Syndrome	_____ Current Infection
_____ Diabetes I II	_____ Cardiovascular Disease	_____ Lupus
_____ Thyroid Problems	_____ Bowel/Bladder Changes	_____ Epilepsy
_____ Immunosuppression	_____ Muscular Dystrophy	_____ Depression
_____ Mental Health Disorder	_____ Obesity	Other: _____
_____ Alzheimer's	_____ Parkinson's	_____
_____ Traumatic Brain Injury	_____ Asthma	

Tobacco Use	Yes	No	Pregnant/Nursing	Yes	No
Alcohol Use	Yes	No	Pacemaker	Yes	No
Marijuana Use	Yes	No			

Please list any surgeries or injuries (fractures, dislocations, sprains, etc.) **associated with your current injury** for which you have been treated or hospitalized including approximate dates:

_____

_____

Please list or attach all prescription and over the counter medications you are currently taking:
*****MEDICARE PATIENTS MUST LIST OR ATTACH MEDICATIONS AND DOSAGES*****

_____

_____

What are the most important things you hope to accomplish with physical therapy?

_____

_____

Patient Signature: _____ Date: _____
(Patient **or** Parent if patient is a minor)

HIPAA CONSENT FORM

By Signing this form, you are granting consent to PNW Physical Therapy to use and disclose your protected health information and electronic protected health information to a third-party provider for the purposes of treatment, payment, and health care operations. PNW Physical Therapy will not disclose your protected health information without your consent. The Notice of Health Insurance Portability and Accountability Act of 1996 provides more detailed information about how we may use and disclose this protected health information. It is your right to review our Notice of Privacy Practices before you sign this consent and may ask to read it in full at any time.

PNW Physical Therapy's Notice of Privacy Practices is subject to change and you have the right to request the revised notices by contacting us.

You have the right to request a restriction of how your protected health information is used. PNW Physical Therapy is not required to agree to the request but if the clinic does agree we must follow these restrictions.

You have the right to revoke this consent in writing at any time, however PNW Physical Therapy may still use this information to complete any actions that began prior to you revoking the consent.

PNW Physical Therapy may refuse your services if you refuse to sign this contract.

With this consent PNW Physical Therapy may call my home or other alternative phone numbers and leave a message on voicemail or to any person answering the phone in reference to any items that assist the office in carrying out treatment, payment, and health care operations; such as appointment reminders, insurance items, and any calls pertaining to my clinical care.

Print Name:_____ Date:_____

Signature:_____

(Patient **OR** Guardian if patient is a minor)

WELCOME LETTER

INSURANCE INFORMATION: As a courtesy to you we will bill your insurance company. Please provide us with your insurance card(s) and any additional information we may need during your first visit. We recommend that you call your insurance company to verify your physical therapy coverage. It is your responsibility to know your policy benefits and limitations. Our billing office is available to answer questions you may have regarding our billing procedures. Please be aware that costs for each session may periodically differ.

PAYMENT OPTIONS: We accept personal checks, cash, and all major credit cards. Insurance copayments are due at the time of service. If we must bill your copay, a service charge may be applied to your bill. Any portion of your treatment that is not covered by your insurance becomes your responsibility and is due within 30 days. Interest may be charged at a rate of 1% each month (12%) annually) for unpaid balances over 30 days old. A $25 fee will be charged for all checks returned as insufficient funds.

WORKERS COMPENSATION CLAIMS: We will bill your OPEN, approved Worker's Comp Claim. Please be advised that in the event your claim is denied you are financially responsible for all charges.

NON-DISCRIMINATION: Admission to our clinic is non-discriminatory for services rendered, regardless of race, color, national origin, disability, or age. All clients who come to our clinic for services are protected against discrimination assured by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

MEDICARE PATIENTS: Medicare requires you to see your doctor 60 days from the start of your physical therapy treatment and every 30 days after in order to continue with physical therapy. Without a current prescription Medicare can deny payment.

PHYSICAL THERAPY SUPPLIES: If supplies are needed, they will need to be purchased by the patient in order to carry out home exercises or treatment. Payments for these supplies are due at time of service. We will provide a receipt to you so you may seek reimbursement from your insurance company. Supplies are not refundable.

Thank you for allowing us the opportunity to serve you. If you have any questions about the above information or your insurance coverage please don't hesitate to ask for our assistance.

Signature: _____ Date: _____

(Patient **OR** Guardian if patient is a minor)

SCHEDULING POLICY

We request **24 hours'** notice by phone call to reschedule appointments. We reserve the right to discharge your case without notice if you:

- **No Show** (no notice of missed appointment) two appointments OR
- **Cancel** (cancelling the day of the appointment) three times in a row

Please provide your email address_____for appointment reminders. You will be sent an appointment reminder a day prior to your scheduled appointments.

Signature:_____ Date:_____

(Patient **or** Guardian if patient is a minor)