8685 W. Union Hills Drive. Peoria, AZ 85382
Phone: 623.486.2331 . Fax: 623.486.3136

2525 W. Carefree Highway, Bldg. 5 #136 . Phoenix, AZ 85085
Phone: 623.580.0111 . Fax: 623.580.9080

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PATIENT INFORMATION FORM

Patient Name ______________________________________ DOB ____________________ Age _____________

Patient SS# _____________________________________ Sex ______________ Marital Status ____________

Home Address ____________________________________ City _____________ State ____ Zip ____________

Home Phone __________________________________ Cell Phone ____________________________________

Email Address ____

Patient's Employer ______________________________________ Work Phone __________________________

Employer's Address ______________________________ City _____________ State ____ Zip ____________

Responsible Party __________________________________ Relationship to Patient _____________________

Address ____ Phone _______________________________

Whom may we thank for this referral? Name: ________________________ Phone:__________________

Insurance Information

Primary Insurance ________________ Policy/ID#___________________ Group#____________________

Address ____ Phone _____________________________

Policy Holder _______________________________ DOB____________ SS#___________________________

Relationship to Patient _____________________ Employer ____

Secondary Insurance _____________ Policy/ID#___________________ Group#_____________________

Address ____ Phone ______________________________

Policy Holder _______________________________ DOB____________ SS#___________________________

Relationship to Patient _____________________ Employer ____

Work Related Injury? ____ **Auto Accident?** _____ **If yes, date of injury** _______________________

Insurance Carrier _____________________ Address ____

Claim # ______________________ Contact ___________________________ Phone_____________________

Emergency Contact Information

Name of person to contact _________________________________ Relationship _______________________

Address ____ Phone ____________________________

Signature:____Date:___________________

Arrowhead Physical Therapy

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MEDICAL HISTORY QUESTIONNAIRE

Name:	Age: Height: Weight: Date:
Dominant hand: Right Left	Referring Physician:
Primary Care Physician:	Employer:
Job Title:	Are You Currently Working: Y N
If yes, are you on restricted duty? Y N	What type of restrictions?
If you had surgery: Date of surgery:	Name of procedure:

Your therapist will review this questionnaire. If you do not understand a question, please just leave it unanswered.

1. Describe your problem for which you are seeking treatment: ____
____

2. How did the injury/problem occur? ____
____

3. When did your injury occur or when was your problem first noticed? Date: ______________________

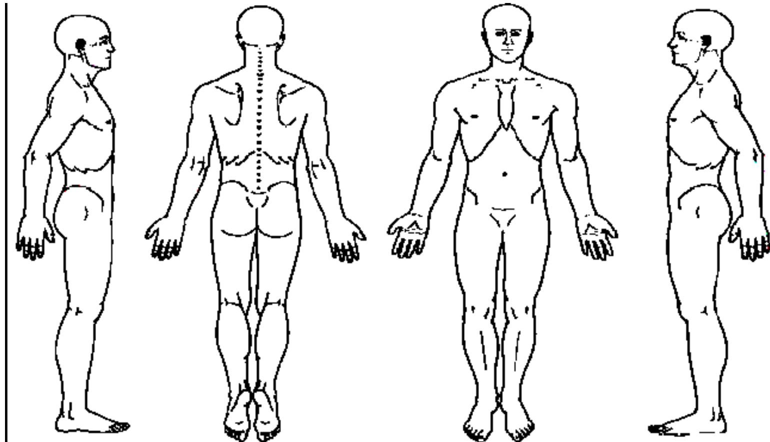
4. Was this a work related injury? ☐ Yes ☐ No

5. Have you had any tests? (For example: X-ray, CT scan, MRI, etc.) Do you know the results?
____
____

6. Please describe your pain using the symbols and pain diagram.

Draw the symbol on the body diagrams:

YYY	Aching
XXX	Burning
===	Numbness
000	Tingling/Pins & Needles
/ / /	Stabbing
SSS	Other___________________



7. Please rate your pain on a scale of 0-10 where 0 is no pain and 10 is emergency type of pain:
Highest _______ Lowest_______ Current______

8. Is your problem getting? □ Worse □ Better □ Staying the same

9. Does your problem disturb your sleep? □ Yes □ No

10. How is your problem first thing in the morning? □ Worse □ Better □ Same

11. How is your problem at the end of the day? □ Worse □ Better □ Same

12. What makes your symptoms worse?
(For example: lying on my right side).

____
____
____
____

13. What makes your symptoms better?
(For example: sitting for 15 minutes, walking up stairs, looking over my shoulder when driving).

____
____
____
____

14. What treatment(s) have you had for this problem thus far?____
____
____

15. Did the treatment you received help your condition? □Yes □□No

16. What medications are you taking?____
____

17. What are your goals for recovery?____

18. What activities are you presently not participating in because of this problem?_____________________________
____

19. Is there litigation (legal counseling) involved? □ Yes □ No

20. Do you have any of the following? (Please circle) heart problems, diabetes, cancer, headaches, vision problems, dizziness, loss of bowel/bladder control or recent weight loss?

21. Any other condition/diagnosis you have had?____
____

22. Past surgeries?____

23. When is your next doctor appointment?___________________ With whom?____________________

Patient/Guardian Signature: ____

Thank you for completing this form. It will be filed with your clinical record.

Consent to Treatment

I authorize the clinical staff of Arrowhead Physical Therapy and Rehabilitation (the Company), to administer, perform and carryout any and all procedures ordered or prescribed by my or my dependant's physician and determined appropriate by the physical therapist. I understand that all care will be administered or directly supervised by an Arizona Licensed Physical Therapist. I understand that any information that I choose to withhold may adversely affect the treatment rendered, and the Company and its employees make no guarantee as to the results of the treatment rendered. I agree to participate in my rehabilitation program as an active participant and will be given the opportunity to ask any questions and/or express concerns related to my condition.

Signature: ____ Date: ________________________________

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed
and how you can get access to this information. Please review it carefully.

1) I understand and agree that *Arrowhead Physical Therapy and Rehabilitation* (the "Company") may transfer my Protected Health Information (PHI) electronically, or by other means, for the purposes of carrying out my treatment, receiving payment for services, or other health care operations.
2) Examples of these transfers may include, but are not limited to the following:
    a. Facsimile or U.S. mail to my referring physician, primary care physician, insurance carrier, Medicare, Medicaid, Industrial Case Manager, attorney involved in my case, licensing, or accrediting agency.
    b. Billing software vendor and/or EMR vendor.
    c. Electronic billing clearing house or agency.
    d. Credit card transactions.
    e. Via the internet for transcription purposes.
    f. Contact me by telephone regarding appointment reminders or missed appointments.
3) I understand that I may request, except in the case of a Workman's Compensation Claim, a copy of the summary of the "Health Insurance Portability and Accountability Act of 1996" published by the United States Department of Health and Human Services prior to signing this consent.
4) I understand that I have the following individual rights regarding the transfer and use of my PHI:
    a. I may request, in writing, except in the case of a Worker's Compensation Claim, that my PHI only be transferred via U.S. mail or place other restrictions on it's use and disclosure, but that the Company is not required to agree to these restrictions.
    b. I, or my legal representative, may obtain copies of my PHI and this Notice except in the case of a Worker's Compensation Claim by contracting the clinic in writing and that copy fees and postage charges will apply.
    c. I may request amendments to incorrect or incomplete PHI.
    d. I may request an accounting of disclosures, but not uses of, PHI for treatment, payment or health care operations.
5) I understand that the Company is required by Federal law to maintain the privacy of my PHI, provide me with this Notice, comply with the terms of this Notice and revise this Notice only as set forth below.
6) I understand that the Company reserves the right to amend uses and disclosures of PHI and, while under active care, I will be notified of such changes and that after discharge from care, I may inquire as to any changes made to privacy policies and that a revised Notice will be provided.
7) I understand that if I believe that my privacy rights have been or are being violated that I may file a complaint in writing to the Company or the U.S. Department of Health and Human Services, Office of Civil Rights, 50 United Nations Plaza, Room 322, San Francisco, CA 94102, and that the Company may not retaliate against me for filing a complaint.
8) By signing below, I agree that I have read and understand the above and enclosed information and agree to allow the Company to transfer documents regarding my care as described above.

9) **A secure phone number that a detailed message can be left at:_______________________________________**

Please contact our Privacy Officer/Practice Administrator, at the above phone number,
if you have any questions regarding this notice.

Print Name: ____
(Patient)

Signature: ____ Date: ______/______/______
(Patient, Guarantor, POA, Parent and/ or Guardian)

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FINANCIAL RESPONSIBILITY

1. I understand that I, ________________________, am responsible for confirming my medical benefits that of my dependant with my carrier/insurance group and that I am expected to have this information at the time of my first visit.
2. I understand that Arrowhead Physical Therapy (APT) cannot guarantee that the information received from my insurance company is accurate. I am fully responsible for all charges posted to my account.
3. I understand that APT's agreement to participate as a "preferred provider" within a specific insurance plan extends to fee schedule agreements only and that I remain ultimately responsible for all services rendered to me or my dependant by APT.
4. I understand that in the event that APT is a "participating" but not "preferred" provider for services, that no agreement exists for discounted fees and I am responsible for any difference in fees charged and reimbursed by my insurance company.
5. I understand that APT will bill my insurance company according to all Federal rules and regulations regarding such activities and provides my insurance company with copies of all appropriate and required information on a weekly basis and that APT is not responsible for lost claims. Outstanding insurance accounts 60 days past due will be automatically turned over to patient responsibility.
6. I understand that APT will make any reasonable effort to assist me in resolving any disputed claims or payment for such claims, but that the contractual relationship for payment of such claims lies solely between myself and my insurance carrier and that I am ultimately responsible for all services provided.
7. I understand that if my plan is out-of-network or services are determined "non-covered" due to plan provisions and/or pre-existing conditions or riders on my policy, I am fully responsible for all services incurred.
8. I understand that if I elect to pay privately at my first visit, due to lack of insurance or failure to verify coverage, APT will NOT retroactively submit claims or change account responsibility.

I, _______________________, attest that this injury **IS NOT** related to a motor vehicle accident.

I, _______________________, attest that this injury is related to motor vehicle accident and have provided all necessary information to APT, including a signed lien agreement.

ASSIGNMENT OF BENEFITS

1. I assign to ***Arrowhead Physical Therapy and Rehabilitation*** (***APT***) the right to receive payments for all health care services rendered by the Company to me or my dependant.
2. I will cooperate, aid, and assist ***APT*** in procuring payments for healthcare services rendered to me or my dependant from any third party that is or may be liable for such services.
3. I understand and agree that I am responsible and must pay all deductibles, co-payments and amounts disputed by my insurance carrier for health care services rendered by ***APT*** to me or my dependant.
4. I understand that a cash discount for uninsured patients is ONLY applicable on payments made at the time services are rendered and does NOT apply to balances that are billed after the service date.
5. I understand that I will be charged a fee of $25 for a returned check because of non-sufficient funds.
6. I understand that I will be charged **a fee of $30** for any scheduled appointment that I fail to appear for unless 24 hours of advance notice is provided.
7. I understand that I may be assessed interest on any amount owed that is over 30 days after the last documented visit at the rate of **3% per month** or the maximum allowed by law. **This is not an APR rate.**
8. I understand and agree that APT may utilize any legal means to collect payment for any health care services rendered to me or my dependant and I will be responsible for an additional **35% collection fee** that APT incurs to collect such past due charges. In the event that legal action is commenced, in order to enforce the terms and conditions of this Agreement, the prevailing party shall be entitled to recovery of all attorney and/or collection fees and costs.

Signature: ____ Date: ________________________________
Patient, POA, Parent and/or Guardian