Arrowhead Physical Therapy

PATIENT INFORMATION FORM

Patient Name_____ Patient SS#_____ DOB_____

Home Address _____City _____State____Zip_____

Home Phone_____Cell Phone _____

Email Address _____

Would you like text message appointment reminders? Yes_____No_____

Would you like your home exercise plan emailed to you? Yes_____No_____

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_____

Primary Insurance_____Policy/ID#_____Group#_____

Address_____Phone_____

Policyholder_____DOB_____SS#_____

Relationship to Patient_____Employer_____

Secondary Insurance_____Policy/ID#_____Group#_____

Address_____Phone_____

Policyholder_____DOB_____SS#_____

Relationship to Patient_____Employer_____

Work-related injury? _____Auto accident? _____If yes, date of injury _____

Insurance Carrier _____Address _____

Claim #_____Contact_____Phone _____

Emergency Contact Name_____Relationship _____

Address_____Phone _____

Signature_____ Date_____

Revised 2/18/2023

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:

Arrowhead Physical Therapy

MEDICAL HISTORY QUESTIONNAIRE

Patient Name_____ **Date**_____

Heart Disease

- ☐ Congestive Heart Failure (CHF)
- ☐ High Blood Pressure (Hypertension)
- ☐ Heart Attack (Myocardial Infarction) (MI)
- ☐ Atherosclerotic Disease (CAD)
- ☐ Angioplasty
- ☐ Valvular Disease
- ☐ Stents
- ☐ Arrhythmia
- ☐ Coronary Artery Bypass Graft (CABG)
- ☐ Angina

Lung Disease

- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Emphysema
- ☐ Asthma
- ☐ Recent Pneumonia

Vascular Disease

- ☐ Peripheral Arterial Disease
- ☐ Acquired Respiratory Distress Syndrome (ARDS)
- ☐ Diabetes
- ☐ Stroke/TIA
- ☐ Chronic Bronchitis

General Medical Conditions

- ☐ Arthritis (Rheumatoid/Osteoarthritis)
- ☐ Allergies
- ☐ Neurological Disease (MS, Parkinson's)
- ☐ Headaches
- ☐ Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)
- ☐ Visual Impairment (cataracts, glaucoma, macular degeneration)
- ☐ Neck Pain
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Degenerative Disc Disease
- ☐ Spinal Stenosis
- ☐ Cancer
- ☐ Osteoporosis
- ☐ Anxiety or Panic Disorders
- ☐ Depression
- ☐ Previous Accidents
- ☐ Kidney, Bladder, Prostrate or Urination Problems
- ☐ Incontinence
- ☐ Hearing Impairment (very hard of hearing even with hearing aids)
- ☐ Sleep Dysfunction
- ☐ Prosthesis/Implants
- ☐ Recent Weight Loss
- ☐ Recent Weight Gain
- ☐ Hepatitis
- ☐ HIV/AIDS

Prior Surgeries? _____

Other Disorders/Conditions? _____

_____ _____

Patient Signature Date Physical Therapist Signature Date

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MEDICAL HISTORY QUESTIONNAIRE

Name:	Age:	Height:	Weight:	Date:
Referring Physician:		Dominant hand:	Right	Left
Primary Care Physician:		Employer:		
Job Title:		Are you currently working:	Y	N
If yes, restricted duty? Y N		Tobacco use?	Y	N
Surgical Procedure:		Date of surgery:		

1. Describe the reason you are seeking treatment. _____

_____

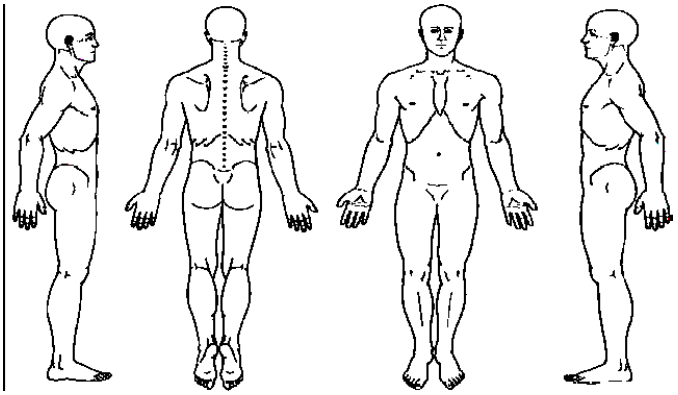
2. How did the injury or your symptoms occur? _____
3. Date of injury or when did your symptoms begin? _____
4. Was this a work-related injury? ☐ Yes ☐ No Was this related to a motor vehicle accident? ☐ Yes ☐ No
5. Is there litigation (legal counsel) involved? ☐ Yes ☐ No
6. Have you had any tests such as X-ray, CT Scan, MRI? If so, please indicate results.

_____

7. 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_____



8. 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_____

9. Are your symptoms getting? □ Worse □ Better □ Staying the same
10. Do your symptoms disturb your sleep? □ Yes □ No
11. How are your symptoms first thing in the morning? □ Worse □ Better □ Same
12. How are your symptoms at the end of the day? □ Worse □ Better □ Same

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13. What makes your symptoms worse? (For example: lying on my right side, looking over my shoulder when driving).

13. What makes your symptoms better? (For example: sitting for 15 minutes, walking slowly).

14. What treatments have you had related to your injury/symptoms and did they help? _____

15. What medications are you currently taking?

Medication	Dose/Frequency	Medication	Dose/Frequency

16. What are your goals for recovery? _____

17. What activities are you presently not participating in as a result of your injury/symptoms? _____

18. When is your next doctor's appointment?_____Doctor's Name _____

Patient/Guardian Signature _____ Date _____

CONSENT TO TREATMENT

I authorize the clinical staff of Arrowhead Physical Therapy (the Company), to administer, perform and carry out all procedures ordered or prescribed by my or my dependent'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 _____
(Patient, POA, Parent and/or Guardian)

Arrowhead Physical Therapy

NOTICE OF PRIVACY PRACTICES

This notice describes how your medical information may be used and disclosed and how you may obtain this information. Please review it carefully.

1) I understand and agree that Arrowhead Physical Therapy (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, email 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. Contact me by telephone regarding appointment reminders or missed appointments.
    f. Carry out follow ups on your home programs or discharge planning.
    g. Advise you of new or updated services or home supplies via email, newsletter, or telecommunications.
    h. Carry out research that does not directly identify you.
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 its 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 contacting the clinic in writing 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 Federal law requires the Company 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 we may use to leave a detailed message** _____

Please contact our Privacy Officer, at the phone number listed below, if you have any questions regarding this notice.

Print Name _____
(Patient)

Signature _____ Date_____
(Patient, Guarantor, POA, Parent and/or Guardian)

Arrowhead Physical Therapy

FINANCIAL RESPONSIBILITY

1. I understand that I, _____, am responsible for confirming my medical benefits, or those of my dependent 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 dependent by APT.
4. I understand that if 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 provide my insurance company with copies of all appropriate and required information on a weekly basis. I understand 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 a 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 I have provided all necessary information to APT, including a signed lien agreement.

ASSIGNMENT OF BENEFITS

1. I assign to Arrowhead Physical Therapy (APT) the right to receive payments for all health care services rendered by the Company to me or my dependent.
2. I will cooperate, aid, and assist APT in procuring payments for health care services rendered to me or my dependent 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 dependent.
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 as a result 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 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 legal action to collect payment for any health care services rendered to me or my dependent and I will be responsible for an additional **35% collection fee** of the balance due. If legal action is commenced, 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)

ARROWHEAD PHYSICAL THERAPY- FIT2LIV PROGRAM

Welcome and thank you for choosing Arrowhead Physical Therapy as the provider of your physical therapy services. At Arrowhead Physical Therapy, our focus is on lifestyle changes both during and after your physical therapy treatment program.

As a patient, you will be provided with the resources, encouragement, and support to enable you to achieve your overall health and wellness goals. Massage therapy and fitness classes, including golf fitness, are offered to our patients throughout their rehabilitation journey.

We encourage you to take advantage of the resources and opportunities available within our practice.

Please select the below programs that may interest you.

☐ Free Fitness Tour: Receive a complimentary tour of our fitness facility, discuss group fitness classes, semi-private and private fitness sessions; single purchase or package discount pricing is available.

☐ Massage Therapy: Receive a one-hour introductory massage for only $48; additional specials, packages and gift certificates are available.

☐ Golf Fitness Evaluation: This one-hour session includes a golf specific physical screen and Body Swing Connection™ evaluation utilizing video analysis with our Titleist Performance Institute Certified Golf Expert for $198; additional golf fitness packages are available.

Patient Name _____ Phone Number _____Date_____

Case # _____ Date/Time Scheduled_____
(For Office Use Only) (For Office Use Only)

Revised 11/11/2022