RS Physical Therapy

New Patient Information Sheet

Welcome to our practice!
Please help us serve you better by taking a few minutes to provide the following information.

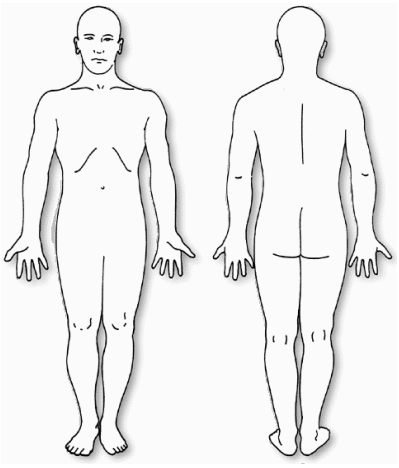
Name:	Last Name	First Name			Today's date:				
Address:									
City / State / ZIP:									
Phone #	MOBILE		HOME		WORK				
DOB:		Age:		Marital status:	M	S	W	D	
Email:									
Occupation:		Employer:							
Emergency Contact	Name:		Phone:						
Primary Care Physician	Name:		Date of next visit						
Specialist Physician	Name:		Date of next visit						

How did you hear about our practice?	
Who can we thank for referring you to our practice?	

Please fill out these forms as specifically as possible to provide us with a clear picture of your present pain and functional status.

What is the primary issue/problem that brings you in today?
Secondary concern/problem?
As a result, I am now having difficulty with:
Are you currently experiencing pain as a result of these symptoms? If yes, what is it like?
When did your symptom(s) begin? (Date):

Please shade in areas where you have pain, discomfort, or tension.



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Please rate your pain in the last 24-72 hours Using the "0 -10" scale where 0 is no pain and 10 is the worst possible pain.	At its worst	
	At its best	
	At present	
	Night (sleeping)	

At what time of day are your symptoms the worst?	
At what time of day are your symptoms the best?	
What activities increase your pain?	
What activities decrease your pain?	

What other types of treatment have you had for this problem?											
	Massage		Bodywork		Physical Therapy		Myofascial Release		Chiropractic		Surgery
Other Medical Treatment: (Please Describe)											

Check the box if you have had any of the following medical conditions?											
	Diabetes		Lung disease		Weight change		Varicose veins		Neurological problems		Pregnancy
	Rheumatic fever		Osteoporosis		Migraine headaches		Epilepsy / seizures		Stroke		Blackouts
	Heart Murmur		Malignancy		Arthritis		Broken bones (fracture		Metal implants		High blood pressure
	Circulatory problems		Liver disease		Heart disease / pacemaker		Kidney disease		**Others (explain below)**		

List past medical history and dates of occurrence. Include surgeries, accidents and other traumas.

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Family History of Major Medical Illness or Condition

Illness/ Condition	Family Member	Illness/Condition	Family Member
Cancer - Type		High Blood Pressure	
Cancer - Type		High Cholesterol or Triglycerides	
Heart Disease		Alcohol or Drug Abuse	
Diabetes - Type		Anxiety/ Depression	
Stroke/ TIA		Other Genetic Disorder	

Please List all Allergies and the Expected Reaction

Allergy	Reaction

List ALL medications which you are currently taking, the condition for which you are using them, the dose, and their effectiveness. (Include supplements, herbal and homeopathic remedies).			
Medication	For treatment of	Dose / Amount per day	Effectiveness

Please List Any Alcohol, Tobacco, or Recreational Drug Use:

Do you use Alcohol?	Yes	No	If “Yes” – How much?	
When did you quit?			If not, Would you like to quit?	

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Do you use Recreational Drugs?	Yes	No	If "Yes" – How much and Indicate what drugs used?	
When did you quit?			If not, Would you like to quit?	

Do you smoke?	Yes	No	If "Yes" – How much?	
When did you quit?			If not, Would you like to quit?	

Is there a chance you may be pregnant at this time?	Yes	No

Do you engage in regular exercise?	Yes	No
What type and how often?		
Are you able to exercise now?	Yes	No

Do you have discomfort, shortness of breath, or pain with exercise?				Yes	No
Please Describe:					
In general, your lifestyle is:	1	2	3	4	5
	Active		Average		Inactive

If sleep is a problem, answer these questions:

Do you have trouble falling asleep?	Yes	No	Do you find it difficult to change positions in bed?	
Is your sleep restful?	Yes	No	How many times do you wake in the night?	
Do you find it difficult to lie down?	Yes	No	How long before you fall back to sleep?	

List all the Tasks / Activities that you have difficulty performing and your tolerance (minutes/hours).

If you are no longer able to perform an activity, your tolerance would be "0".

Task / Activity	Tolerance (minutes/hours)

I walk for		**minutes before needing to rest**

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I stand for		**minutes before needing to sit**		
I sit for		**minutes before needing to change positions/get up**		
Do you have trouble getting up from a chair?			Yes	No
Do you have trouble putting on your shoes and socks?			Yes	No
Do you have difficulty climbing stairs?			Yes	No

Patient Goals

Please list the activities that you would like to be able to do as a result of therapy.

Task / Activity	Duration / How Often	By When
Other Goals?		

Insurance Information:

Primarv Insurance:_____ Phone Secondary Insurance:_____

Insurance Company:_____Insurance Company:_____

Phone:_____Phone:_____

Policy/ID #:_____Policy/ ID#:_____

Group #:_____Group #:_____

Insured Name:_____Insured Name:_____

Relationship to insured:_____Relationship to insured:_____

Social Sec #_____ Social Sec # _____

DOB: _____ _____DOB: _____

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INFORMED CONSENT

I understand that Performance & Recovery Lab will maintain my privacy to the highest standards and 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 give my consent Performance & Recovery Lab to evaluate my condition and furnish physical therapy treatment as considered necessary and proper by the Physical Therapist, through its appropriate personnel, agents and affiliates to perform the evaluation, care and treatment procedures that are deemed necessary by my physician(s) and other healthcare providers and Physical Therapist.

Patients/clients need to know:

- The purpose of any examination/assessment or intervention/treatment
- Any risk associated with the proposed intervention/treatment
- The expected benefit of the intervention/treatment
- Reasonable alternatives to the proposed intervention/treatment
- I understand that no warranties or guarantees have been made to me about the outcome of my Care.

Patients/clients have the right to:

- physical therapy services without discrimination
- services provided by physical therapists who are free to make clinical and ethical judgments without outside interference according to their education and experience
- request a second opinion from another physical therapist at any stage
- physical therapy services provided in accordance with their best interests
- choose freely and change their physical therapist or health service institution
- decline examination/assessment and intervention/treatment at any stage, without it prejudicing future management
- receive information about themselves recorded in their health records
- receive information about practice policies, charges for services, physical therapy goals, desired outcomes and procedures
- choose who, if anyone, should be informed on their behalf
- discuss the physical therapy intervention/treatment options, benefits, risks and side effects

ACKNOWLEDGEMENT OF PATIENT RIGHTS & INFORMED CONSENT (Initial _____)

RELEASE OF MEDICAL INFORMATION

Performance & Recovery Lab uses your personal health information primarily for treatment; obtaining payment of treatment; conducting internal administrative activities, and evaluating the quality of care that we provide. For example, Performance & Recovery Lab, may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you. Performance & Recovery Lab, may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law. In any other situation, Performance & Recovery Lab Physical Therapy's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization through a written statement to stop future disclosures at any time. Performance & Recovery Lab, may change its policy at any time.

A.R.S. 12-2295 Except as otherwise provided by law, a health care provider or contractor may charge a person who requests copies of medical records a reasonable fee for the production of the records. Except as necessary for continuity of care, a health care provider or contractor may require the payment of any fees in advance.

A fee of $85 may be charged for requested copies of medical records for use other than continuity of care with other healthcare providers.

I authorize Performance & Recovery Lab to release any medical information about me to my insurance company or worker's compensation carrier for the processing of any medical claims filed on my behalf. I also authorize to release, receive, and/or discuss my medical information with any other medical provider(s) who have, are, or will be participating in my medical care.

RELEASE OF MEDICAL INFORMATION (Initial _____)

I authorize Performance & Recovery Lab to speak to the following person(s) regarding my medical care, treatment, and/or billing information:

Name: _____ , phone number _____ , and relationship _____

Name: _____ , phone number _____ , and relationship _____

I understand that I have the right to revoke this authorization at anytime.

RELEASE OF MEDICAL INFORMATION (Initial _____)

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HIPAA Acknowledgement

I acknowledge that I have received the practice/clinic's Notice of Privacy Practice/clinics, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice/clinic's Notice of Privacy Practice/clinics.

DIGITAL IMAGES AND VIDEOS

I understand that photographs and digital videotapes may be recorded to document my care and consent to this. I understand that Performance & Recovery Lab retains ownership rights to these digital images/videos but I will be able to request a copy. Images that identify me will be released and/or used outside of Performance & Recovery Lab only upon written authorization from me or my legal representative only if they are released for purposes other than treatment, payment, or healthcare operations. Photographs may be taken during initial evaluation, progress evaluation and discharge summary. By signing below I consent to the use of these photographs and in a professional manner. I understand that I am not permitted to take pictures or make video or audio recordings at any Performance & Recovery Lab location or clinic or of my care, other patients or Performance & Recovery Lab personnel.

Consent to mail, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

We want to stay connected with our patients. Patients in our practice/clinic may be contacted via email, calls to your cellular telephone (including prerecorded/artificial voice messages and/or calls from an automatic dialing device), and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information.If at any time, you provide an email, cellular telephone number, address or text number below, you understand that you may get these communications from the Practice/clinic. You may opt out of these communications at any time with written consent.The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

● I authorize to receive text messages and/or cellular telephone calls for appointment reminders, feedback, and general health reminders/information and the cell phone number is: _____ (Initial ____)

● I authorize to receive email messages for appointment reminders and general health reminders/feedback/information and the email that is: _____ (Initial ____)

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CANCELLATION / NO SHOW POLICY

I hereby acknowledge that I have reviewed NO SHOW, CANCELLATION & LATE ARRIVAL policy and I understand a $65 fee will be charged to me for each appointment I do not give a 24- hour notice and/or for each appointment I am more than 15 minutes late.

CANCELLATION/NO SHOW POLICY (Initial ___)

Payment Policy

Payment, in the form of cash, check or credit card, is due at the time of each visit.

RESPONSIBILITY FOR PAYMENT: All co-payments are due at the time of service. I acknowledge that in consideration of the services provided to me by Performance & Recovery Lab, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide Performance & Recovery Lab with current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. My health insurance plan may provide that a portion of the charges and balance will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible.

We are not contracted with all insurance companies. However, the payments you make may be reimbursable by your insurance company under your out of network physical therapy benefits; the exact percentage depends upon your plan. Due to the complex nature of insurance claims and reimbursement, I make no promises as to whether you will receive reimbursement.

DIRECT PAYMENT NOTIFICATION: Arizona state constitution permits you to pay a healthcare provider for health care services directly. If you elect to use cash based or direct payment, full payment is expected at time of service.

We will assist you in every way possible.

Payment is due at the time of service.

PAYMENT POLICY (Initial _____)

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It is expressly agreed that all exercises and treatments and use of all facilities shall be undertaken at the patients/ members own risk, and the member represents that he/she is physically able to understand and and all physical exercises and treatments provided Performance & Recovery Lab shall not be liable for any claims, demands, injuries, damages, actions, or causes of action

whatsoever to the member/ patient arising out of, or connected with the use of any of the services, and/or facilities.

Patients/ Member does hereby expressly forever release and discharge Performance & Recovery Lab attended and / or all of their affiliated companies from all such claims, demands, injuries, damages, actions or causes of section, and from all facts of active or passive negligence on the part of such companies, corporations, clubs, studios, their servants, agents, or employees

I do hereby agree and give my consent for Performance & Recovery Lab. to furnish care and treatment that is considered necessary and proper in the diagnosing or treating of my physical condition.

I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

I hereby certify that all the above information is true to the best of my knowledge.

I have read and understand the above policies.

Patient Signature

_____ _____

Printed Patient Name ***Printed Parent/ Guardian Name***

_____ _____

Patient/Parent/Guardian Signature ***Date***

Thank you for your cooperation and business.

Saurabh Patel, PT, DPT

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