ALPHA & OMEGA PHYSICAL THERAPY

PATIENT INFORMATION

DATE:_____

NAME:_____ ☐ **MALE** ☐ **FEMALE** **MARITAL STATUS**_____

MAILING ADDRESS: _____ **CITY:**_____ **STATE:**_____ **ZIP:**_____

PHONE:_____ **DATE OF BIRTH:**_____/_____/_____ **AGE:** _____ **SS#:**_____-_____-_____

EMPLOYER:_____

MAILING ADDRESS: _____ **CITY:**_____ **STATE:**_____ **ZIP:**_____

OCCUPATION:_____ **WORK PHONE:**_____ **DRIVERS LIC.#:** _____

EMERGENCY CONTACT:_____ **PHONE:** _____

PERSON RESPONSIBLE FOR CHARGES:_____ **RELATIONSHIP TO PATIENT:** _____

MAILING ADDRESS: _____ **CITY:**_____ **STATE:**_____ **ZIP:**_____

PHYSICIAN INFORMATION

PHYSICIAN: _____**PHONE:**_____

MAILING ADDRESS: _____ **CITY:**_____ **STATE:**_____ **ZIP:**_____

INSURANCE INFORMATION

Please complete **ALL** fields, when applicable.

NAME OF PRIMARY POLICY HOLDER: _____ **DATE OF BIRTH:** _____/_____/_____

MAILING ADDRESS: _____ **CITY:**_____ **STATE:**_____ **ZIP:**_____

PHONE: _____ **RELATIONSHIP TO PATIENT:**_____ **SS#:** _____-_____-_____

EMPLOYER:_____ **WORK PHONE:**_____

PRIMARY INSURANCE COMPANY: _____ **PHONE:** _____

INSURANCE ADDRESS: _____ **CITY:**_____ **STATE:**_____ **ZIP:**_____

ID NUMBER: _____ **GROUP NUMBER:**_____

DOES THE PATIENT HAVE ADDITIONAL INSURANCE COVERAGE (SECONDARY)? YES NO (IF YES, CONTINUE NEXT SECTION)

NAME OF SECONDARY POLICY HOLDER: _____ **DATE OF BIRTH:** _____/_____/_____

MAILING ADDRESS: _____ **CITY:**_____ **STATE:**_____ **ZIP:**_____

PHONE: _____ **RELATIONSHIP TO PATIENT:**_____ **SS#:** _____-_____-_____

EMPLOYER:_____ **WORK PHONE:**_____

SECONDARY INSURANCE COMPANY: _____ **PHONE:** _____

INSURANCE ADDRESS: _____ **CITY:**_____ **STATE:**_____ **ZIP:**_____

ID NUMBER: _____ **GROUP NUMBER:**_____

MEDICAL HISTORY

PLEASE ANSWER ALL QUESTIONS AS THROUGHLY AS POSSIBLE. ALLINFORMATION WILL BE KEPT CONFIDENTIAL.

What is the primary problem (s) you would like you Physical Therapist to Address?

_____

_____.

How long have you had the problem (s).

_____

_____.

What activities/movements ***increase*** your pain?

_____

_____.

What activities/movements ***decrease*** your pain?

_____

_____.

What is your occupation? _____.

What activities / sports / hobbies do you engage in?

_____

_____.

What do you hope to accomplish or gain from Physical/Occupational Therapy?

_____

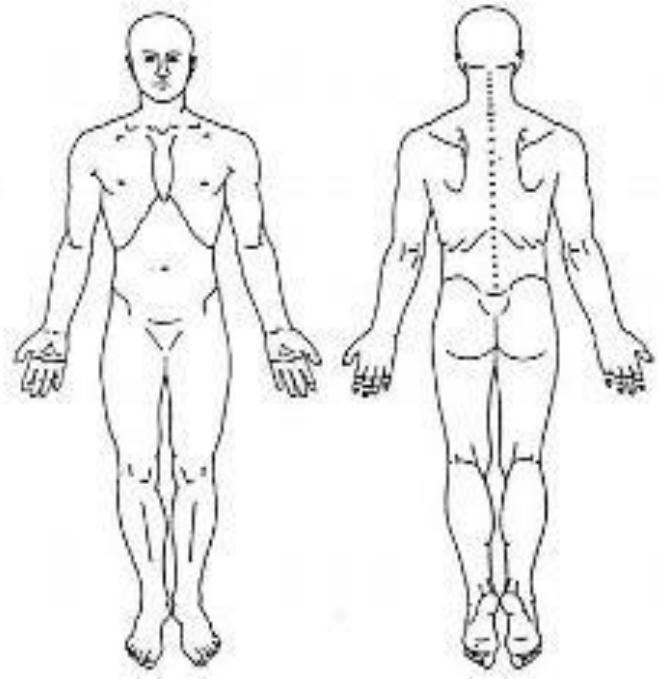
_____.

Have you ever had Physical/Occupational Therapy before? Yes No (If yes, please list)

Date:_____ Location:_____ Condition:_____

Date:_____ Location:_____ Condition:_____

Please indicate with an "X" where your current pain or problem(s) are located.



On a scale 0 to 10, circle the number that best describes the **intensity** of your pain today.

0 1 2 3 4 5 6 7 8 9 10

MEDICAL HISTORY CONTINUED

PLEASE CHECK ALL CONDITIONS THAT YOU HAVE HAD OR CURRENTLY HAVE AND EXPLAIN BRIEFLY BELOW:

	AIDS/ HIV		FRACTURES		PACEMAKER		
	ALLERGIES		HEART DISEASE		PREGNANCEY		ARE YOU PREGNANT
	ANEMIA		HEART ATTACK		PSYCHIATRIC TREATMENT		
	ARTHRITIS		HEART MURMER		SEIZURES / CONVULSIONS		
	ASTHMA		HEPATITIS		SHORTNESS OF BREATH		
	BACK/ NECK TROUBLE		HERPES		STOMACH ULCERS		
	BLEEDING DISORDERS		HIGH BLOOD PRESSURE		STROKE		
	CANCER		IMPLANT		SWELLING OF LIMBS, HANDS, FEET		
	CHEST PAIN		JANDICE		THYROID DISEASE		
	DIABETES		JOINT REPLACEMENT(S)		TUBERCULOSIS		
	DRUG ABUSE		LYME DISEASE		WEIGHT GAIN IN PAST YEARS		
	FAINTING		MOTOR VEHICLE ACCIDENT		WEIGHT LOSS IN PAST YEARS		

PLEASE CHECK IF YOU ARE ALLERGIC TO ANY OF THE FOLLOWING:

MEDICATION ALLERGIES

	LATEX		LOTIONS		SHELLFISH	
	RUBBER		BEES		CORTISONE	
	TAPE		STRAWBERRIES		MEDICATION: (PLEASE LIST) ▶	

PLEASE CIRCLE ANY OF THE FOLLOWING THAT YOU WEAR: GLASSES DENTURES CONTACTS

HAVE YOU HAD ANY SIGNIFICANT OPERATIONS, SURGERIES OR SERIOUS INJURIES, FRACTURES, STRAINS OR DISLOCATIONS? (PLEASE LIST)

_____

_____

_____

_____

MEDICATIONS: (PLEASE LIST)

ASIDE FROM YOU PRIMARY CARE OR REFERRING PHYSICIAN, ARE YOU UNDER THE CARE OF ANY OTHER MEDICAL/HEALTH CARE PROVIDER OR PHYSICIAN? IF YES, PLEASE LIST AND PROVIDE THE NAME AND PHONE #.

NAME:_____ PHONE:_____ CONDITION:_____

NAME:_____ PHONE:_____ CONDITION:_____

TO THE BEST OF MY KNOWLEDGE, THE INFORMATION PROVIDED HEREIN IS CORRECT.

_____ _____

SIGNATURE **DATE**

ALPHA & OMEGA PHYSICAL THERAPY

CONSENT TO TREATMENT

PATIENT NAME:_____ DATE:_____

1. **I have presented myself for physical therapy treatment to Alpha & Omega Physical Therapy and consent to examination and treatment provided by my attending Physical Therapist / Occupational Therapist.**

2. **I have the right to refuse or decline any examination, treatment, or procedures to the extent permitted by law in the state of Arizona. I acknowledge the physical therapy/occupational therapy is not an exact science; no guarantees or warranties can be made regarding the result(s) of my treatment at Alpha & Omega Physical Therapy.**

3. **I consent the release of copies of my examination and/or treatment records to referring physician(s) and/or third party payer (insurance companies) for the sole purpose of communication between Alpha & Omega Physical Therapy and the referring physician(s) and in order to properly process claims associated with my treatment. I also understand that I must give separate, written consent to allow Alpha & Omega Physical Therapy to release copies of my treatment records to any other parties (attorneys, non-referring physicians, etc.)**

Responsible Party Signature:_____ Date:_____

Relationship To Patient:_____

ALPHA & OMEGA PHYSICAL THERAPY

PRIVACY POLICY

Our privacy policy is provided to help you understand how we protect your personal privacy. This policy provides you with an opportunity to make informed choices about the management of your personal privacy. Our policy will continue to cover information during the course of our relationship has ended.

You have the right to know how we use or disclose your personal information. There are certain uses and disclosures of your personal information that we are permitted or required to make by law without your permission, In addition you have:

- The right to request that we place additional restrictions on our uses and disclosures of your personal medical information, but we are not obligated to agree to any such restrictions.
- The rights to access, inspect, and copy the protected information pertaining to you that we maintain in our files and the right to request that we correct or amend and personal medical information that we have about you.
- The right to receive an accounting of the disclosures of your personal medical information in a confidential manner.
- The right to obtain a paper copy of this notice.

Payment Functions: We may disclose or use your protected medical information without your permission to carry our activities relating to your treatment. For example, payment functions may include (but not limited to) reviewing insurance policy information with respect to medical necessity, coverage under policy, appropriateness of care or justification of charges.

Health care Operations: We also may use or disclose your protected medical information without your permission to carry out physical therapy related activities. For example, discussing your case with various healthcare workers involved. (I.e. your physician, surgeon, radiologist, case worker, etc.)

Use Permitted by Law: We may also use or disclose your protected medical information without your permission for purposes required by law.

Complaints about Misuse of Information: If you believe your privacy rights have been violated you may complain wither directly to us or to the Secretary of Health and Human Services. You will not be retaliated against in any way for filing a complaint. Please call us if you have questions or comments: You may submit all complaints in writing to the following addresses:

Alpha & Omega Physical Therapy
Attn: Compliance Officer
861 E. Cooley Street, #B
Show Low, AZ 85901

U.S. Dept. of Health & Human Services
Attn: Secretary
200 Independence Ave. S.W.
Washington, D.C. 20201

Effective Date: October 1, 2015

Signature: _____ Date: _____

ALPHA & OMEGA PHYSICAL THERAPY

FINANCIAL POLICY

Thank you for choosing Alpha & Omega Physical Therapy - we are committed to providing you with the best possible service and ask that you read and acknowledge the terms of our Financial Policy.

PAYMENT: All payments including co-pay, coinsurance and deductible are due on the date of service. We accept cash, checks, Visa and MasterCard credit cards. As a courtesy to our patients, we will contact your insurance provider to verify your physical therapy coverage. We cannot, however, guarantee the accuracy of the information we receive from your insurance provider.

COINSURANCE/DEDUCTIBLE: If you have a plan with coinsurance percentage or deductible which has not been met, we will estimate the coinsurance/deductible amounts based on what we have been lead to expect your insurance company will pay. Please note that any payment made on the date of service is considered a **DEPOSIT** toward your **ESTIMATED** patient balance. Because this is an estimate, there is always the possibility that you may be either responsible for an additional balance or due a refund. If a refund is due – it will be promptly provided. If it turns out that your insurance company payment is less than expected – you are responsible to promptly pay any additional balance due. An unpaid balance over 30 days past due may be referred to a collection agency.

***I have read and understand the above. Please initial here: _____**

INSURANCE: We encourage you to call your insurance company with any specific questions related to your policy's outpatient physical therapy benefits such as deductible, copayment, coinsurance, visit limitations i.e., sharing of outpatient benefits with acupuncture, chiropractic or occupational care, effective annual calendar renewal date, or any pre-authorization requirements. Alpha & Omega Physical Therapy cannot assume responsibility for incorrect information provided to us concerning your insurance policy. Our courtesy verification of eligibility and benefits does not guarantee that your insurance company will pay for all services provided. Your insurance policy is a contract between you and your insurance company. You are responsible for knowing your level of coverage and are ultimately responsible for the full payment of your bill.

I have read and understand the above Alpha & Omega Physical Therapy Financial Policy, agree to the terms, and understand that I am ultimately responsible for payment of the health care services provided.

_____ _____

Printed Patient Name **Printed Name of Guarantor (if applicable)**

_____

Signature of Patient (or Guarantor) **Date**