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:**_____

ALPHA & OMEGA PHYSICAL THERAPY

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?

_____

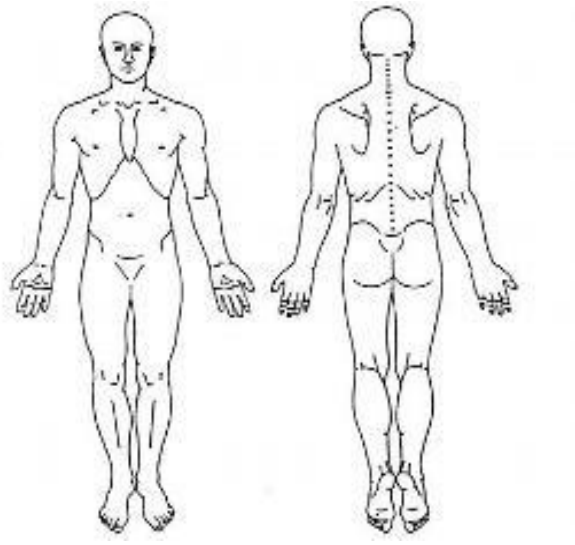
_____.

Have you ever had any Physical Therapy this year? 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

ALPHA & OMEGA PHYSICAL THERAPY

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 <u>ALLERGIC</u> 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

Billing & Financial Policies

Alpha & Omega Physical Therapy recognizes the importance of the successful operation of our practice. It is our hope that you will understand that our financial policy is a necessary part of assuring the financial resources required to maintain the vital health care services for our patients and the community. Our goal is to provide quality care and to communicate to our patients the financial expectations in providing care.

Our billing offices are not located on-site. Our billing department staff can be reached at (623)594-4832. Please feel free to contact them directly or we invite you to communicate with our on-site front office staff. The staff can communicate any concerns or questions you may have to our billing staff. Our office is on a computerized billing system. Patients will receive statements once your insurance carrier has processed the claims and as long as all or part of any portion of the bill remains unpaid. Payments of co-pays, co-insurance or un-met deductibles are expected at time of service. Please do not disregard billing statements.

PPOs, HMOs, Managed Care and other Contracted Plans - We are contracted with a variety of insurance plans to provide therapy services. Most of these plans require the patient to have a referral or prescription to begin therapy services. Many plans require prior authorization for Physical Therapy services. You may be asked or required to obtain a referral or authorization from either your primary care physician or your insurance plan before any services can be provided to you. We will do our best to work with you and your contracted plan to obtain what is needed. However, it is the responsibility of the patient to communicate with the insurance plan to determine needed authorizations/referrals as plan required. Payment of unauthorized services will remain the patient' s responsibility.

Medicare-Part B - We are participating providers with the Medicare program. You are responsible for your yearly deductible and 20% of the allowable charges. Please advise us if Medicare is your secondary payer. If you only have Medicare Part A, you do not have coverage for physician charges. Please advise us if your Medicare Part B plan is provided through Medicare Replacement Plan coverage. Medicare Replacement Plans TYPICALLY REQURE PRIOR AUTHORIZATION/NOTIFICATION.

Supplemental Insurance - If you have supplemental coverage, we will automatically submit your claims to them if the insurance information has been provided. if your supplemental insurance pays you, we expect you to forward those payments to us.

Non-Contracted Insurance - Payment is expected at time of service and we will give you all the information you will need to bill your own insurance. All medical expenses are the patient's responsibility regardless of insurance coverage.

ALPHA & OMEGA PHYSICAL THERAPY

Billing & Financial Policies Continued

Cash-No Insurance Coverage - Patients who have no insurance coverage are considered "Direct Pay" patients. Direct Pay patients are expected to pay at the time of each service session. Direct Pay fees are determined on an individual basis. You may be asked to complete an "Ability to Pay' form for determination of fees.

Workers Compensation - If you have a work-related or industrial injury/illness, please provide us with complete billing information and Case manager contact information. We may be required to obtain authorization from the industrial carrier for any service. Any claim denied as "non-industrial" or "closed" may be billed to your medical insurance carrier or will become your responsibility.

Automobile or Motor Vehicle Accidents. Legal, Lien - Regardless of litigation pending on any case, accident, or otherwise, you are responsible for payment of any and all services rendered to you. Payments cannot be contingent on any settlement, judgment, or verdict for which you may be paid as a result of your injuries. We do not accept liens. We expect payment at the time of service. We will not wait for automobile or third-party insurance settlements. We will bill your medical insurance if information is provided.

Paying your bill - Unusual circumstances sometimes make it impossible for you to pay for services in full; we invite you to please call to discuss the matter with our billing office staff. We want to do our best to work with you. Communication will avoid misunderstandings and keep your account in good standing. If you have any questions, please do not hesitate to ask. We also have information available regarding **CARECREDIT** plans which offer interest free lending for medical care. We will assist you in any way we can. We accept VISA/ MASTERCARD.

Returned checks incur a @25.00 service charge.

Information - Please make sure we have accurate and up-to-date information for billing your insurance. It is also important to advise us of any changes to your name, address, and telephone numbers.

Our billing department contact information (623) 594-4832.

I acknowledge that I have read and understand the Financial Policy of Alpha & Omega Physical Therapy.

_____ _____

Responsible Party Signature Date