Ahwatukee Physical Therapy
New Patient Paperwork

Patient Information

Name: _____ Email: _____

Date of Birth: _____ Age: _____ Sex: _____ Height: _____ Weight: _____ Marital Status: _____

Home Phone: _____Work Phone: _____ Cell Phone: _____

Which number may we disclose personal clinical information on? ☐Home ☐Work ☐Cell ☐Other: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Responsible Party (for patients under 18)

Name: _____ Email: _____

Date of Birth: _____ Age: _____ Sex: _____ Relationship to Patient: _____

Home Phone: _____Work Phone: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer Information

Employer Name: _____ Phone Number: _____ Position: _____

Primary Care Physician Information

Doctor's Name: _____ Phone Number: _____ Fax Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Referring Doctor (if different than PCP)

Doctor's Name: _____ Phone Number: _____ Fax Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance Information

Insurance Company: _____ Policy Number: _____ Group Number: _____

Name of Insured: _____ Relationship: _____ DOB: _____

Secondary Insurance Information

Insurance Company: _____ Policy Number: _____ Group Number: _____

Name of Insured: _____ Relationship: _____ DOB: _____

I certify that all of the information above is to the best of my knowledge and belief true, correct and complete. I will inform Ahwatukee Physical Therapy of any demographic changes to remain consistent with treatment, billing purposes and conducting internal administrative activities

Signature: _____ Date: _____

History and Physical Condition Information

Name: _____ DOB: _____

Problem to be treated: _____

When did the injury occur: _____

Have you had treatment for this problem before? ☐Yes ☐No

If yes, when and where: _____

Briefly describe the history of your present condition:

_____

_____

_____

Have you ever had physical therapy before: ☐Yes ☐No

Are you currently pregnant? ☐Yes ☐No

Are you currently taking any medications? ☐Yes ☐No

If yes, please list all medications
(Medicare patients please attach a separate list):

_____

_____

_____

List any other illness or surgeries that have occurred in the past year:

_____

_____

Please list any other major illnesses or surgeries, both related and unrelated to your current state, that have occurred:

_____

_____

_____

Are your symptoms:
☐Getting better ☐Staying the same ☐Getting worse

How are you able to sleep at night?
☐Fine ☐Moderately difficult ☐Only with medication

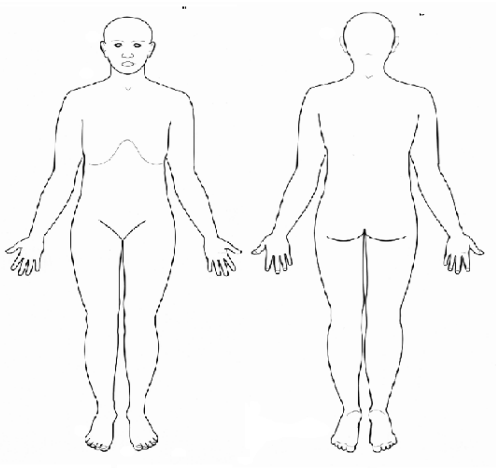
On a scale from 1-10, where 0 is no pain and 10 is worst pain imaginable, how much pain do you experience at best and worst? Select up to three.

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Please diagram to the right your areas of discomfort using the following key:
XXX = Aching 000 = Numbness/Tingling
///=Stabbing SSS: Shooting

Do you now or have you ever had any of the following?

☐Allergies	☐Anemia
☐Asthma	☐Balance Problems
☐Blood borne pathogens	☐Cancer
☐Changes in appetite	☐Changes in bowel/bladder func.
☐Chemical dependency	☐Depression
☐Diabetes	☐Trouble keeping balance
☐Difficulty swallowing	☐Dizzy spells
☐Fever/chills/sweats	☐Headaches
☐Hearing Problems	☐Heart Attack
☐Heart Disease	☐Hernia
☐High Blood Pressure	☐Kidney/liver problems
☐Lung problems	☐Metal Implants
☐Multiple sclerosis	☐Nausea/vomiting
☐Nervous Disorders	☐Osteoporosis
☐Pacemaker/defibrillator	☐Pain at night
☐Parkinson's disease	☐Rheumatoid Arthritis
☐Seizures	☐Sensitivity to heat/ice
☐Shortness of breath	☐Stomach ulcers
☐Stroke	☐Thyroid problems
☐Vision Problems	☐Weakness/fatigue
☐Weight loss/gain	☐Other: _____



Signature: _____ Date: _____

Finance Policies

Ahwatukee Physical Therapy is committed to providing the highest level of medical care to our patients. To ensure that our patients fully understand our billing process, we ask that you read and sign this financial policy statement.

Cash Accounts: Payment for service is due in full at the time of service. If you do not have insurance or the doctor is not a participating provider with your insurance plan, please be prepared to fully cover the fees for each visit at the time of treatment.

Private and Group Insurance Plans: You are required to pay your copay, coinsurance or deductible payment at time of service, all which you are responsible for. The support staff of Ahwatukee Physical Therapy will bill your insurance company once you have provided your insurance information and a copy of your insurance card(s). This service is provided as a courtesy to you; you are ultimately responsible for prompt and full payment for all services provided. We accept cash, check and all major credit cards. Please be advised that there will be a $25 charge to your account for returned checks.

Your insurance is a contract between you, your employer if applicable, and your insurance company. It is the responsibility of the patient to know their benefits and if prior authorization is required by their insurance company prior to physical/occupational therapy treatments. Failure to obtain authorization may affect the benefits paid by your insurance company. It is your responsibility to pay for all the services regardless of any agreement you have with an insurance company, employer, union, government or legal suit.

If your insurance company fails to pay the claim in a timely manner, you are responsible for the payment of the contract amount in full.

Medicare: We at Ahwatukee Physical Therapy are authorized by Medicare to provide physical/occupational therapy services. We will submit a completed claim electronically to Medicare for you. You are required to pay your copay, deductible or coinsurance payment of either Medicare or supplemental insurance at time of service, all which you are responsible for.

Personal Injury: Motor vehicle accidents and attorney lien cases must be approved by Ahwatukee Physical Therapy before initiating treatment. You must provide staff members with a claim number and the information of the adjuster or lawyer assigned to your case. You are responsible for obtaining accepted liability from the third party insurance prior to obtaining treatment. The staff at Ahwatukee Physical Therapy will bill your third party insurance. You are responsible for payment at the time of service if you do not have any of the above stated coverage.

Worker's Compensation: If your injury is work-related, you must provide Ahwatukee Physical Therapy with your claim number and carrier name prior to your visits in order to bill the Worker's Compensation insurance company. You are responsible for ensuring all prior authorization is obtained prior to treatment.

Fees: All copays, coinsurance, deductibles and payments for non-covered services are due at the time of service. If an insurance claim is denied, all related fees are due at the time of notification to the patient. Should the account be referred for collections, the undersigned shall pay reasonable collections expenses including attorney's fees.

I authorize Ahwatukee Physical Therapy to furnish my insurance company and my physician with all information requested concerning my illness or injury. I authorize and assign any and all money payable to me under the terms of any insurance policy, contract or third party entitlement as a result of the services provided by Ahwatukee Physical Therapy to Ahwatukee Physical Therapy. I understand that I am financially responsible for all charges not covered by my insurance.

Signature: _____ Date: _____

Notice of Patient Information Practices

This notice describes how medical information about you may be used or disclosed and how you can get access to information. Please take the time to read it carefully.

Ahwatukee Physical Therapy (APT) is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

Uses and Disclosures of Health Information

APT uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities and evaluating the quality of care that we provide. For example, APT 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.

APT 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 for any reason you may later revoke that authorization to stop future disclosures at any time.

In any other situation APT's policy is to obtain your written authorization before disclosing your personal information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosure at any time.

APT may change its policy at any time. When changes are made, a new Notice of Information Practices will be made available to you. You may also request an updated copy of our Notice of Information Practices at any time.

Patient's Individual Rights

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate information in your records. You also have the right to request a list of instances where we have disclosed your personal information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we don't use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorizes by you, when required by law or emergency circumstances. Ahwatukee Physical Therapy will consider such requests on a case by case basis, but the practice is not legally required to accept them.

Concerns and Complaints

If you are concerned that PT may have violated your privacy rights of if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our office at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Ahwatukee Physical Therapy's health information practices or if you have a complaint, please contact the following:

Ahwatukee Physical Therapy
4405 E. Ray Rd. Ste. 1, Phoenix, AZ 85044
Phone: 480-785-1043 Fax: 480-785-1124

I have read and fully understand Ahwatukee Physical Therapy's Notice of Patient Information Practices. I understand that Ahwatukee Physical Therapy may use or disclose my personal health information for the purpose of carrying our treatment, obtaining payment, evaluating the quality of services provided, and for any administrative operations related to treatment or payment. I understand I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that Ahwatukee Physical Therapy will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as notice in Ahwatukee Physical Therapy's Notice of Patient Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Signature: _____ Date: _____

Cancellation Policy

In consideration of your fellow patients and providers, please notify us if you are unable to keep your scheduled appointment at least 24 hours in advance. This will help alleviate scheduling conflicts, which result in longer patient wait times in addition to helping therapists uphold their schedules and maximizing continuity of care.

Failing to notify with 24 hour notification or failure to present to your appointment may result in a **$25 charge per occurrence.**

Any late cancellation or no show fees will be charged directly to the patient and not to any health insurance, 3rd party payers or attorney liens. All fees must be paid before next appointment.

I have read and understand the 24 hour notice policy, knowing I may be penalized for non-compliance.

Signature: _____ Date: _____

Consent to Treat

I, _____, hereby give consent to receive treatment for

Patient's name

physical therapy at Ahwatukee Physical Therapy starting as of _____.

Today's date

Signature: _____ Date: _____