Returning Patient Paperwork - 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

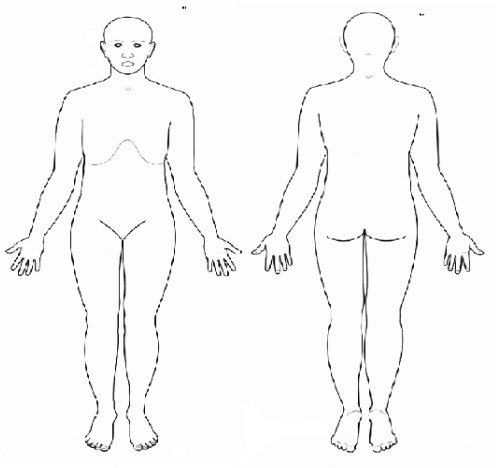
On a scale from 1-10, where 0 is no pain and 10 is worst pain imaginable, how much pain do you experience at best and worst? Select up to three.

☐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 is due at time of service.

Private and Group Insurance Plans: You are required to pay your copay or portion of your deductible at time of service, both which you are responsible for. The support staff of Ahwatukee Physical Therapy will bill your insurance company once you have provided you insurance information and a copy of your insurance card/cards. 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 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 contact 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.

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: _____

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.**

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: _____