CONSENT FOR CARE AND TREATMENT:

I, the undersigned, do hereby agree and give my consent to **Contact Physical Therapy** to provide medical care and treatment to **(patient's printed name)** ____, considered necessary and proper in diagnosing or treating my/his/her physical condition.

Patient/Guardian/Responsible Party Signature ____ Date ______________

BENEFIT ASSIGNMENT / RELEASE OF INFORMATION:

I authorize **Contact Physical Therapy** to release to my insurance company any medical information necessary to process claims for treatment that I and/or my dependent(s) receive under their care in order to secure payment. I authorize payment of any insurance benefits for physical therapy services be paid directly to Contact Physical Therapy.

Patient/Guardian/Responsible Party Signature ____ Date ______________

FINANCIAL POLICY / NOTIFICATION OF PATIENT RESPONSIBILITY:

Contact Physical Therapy will bill your insurance carrier solely as a courtesy to you. If any payment is made directly to you for services billed, you recognize an obligation to promptly submit same to Contact Physical Therapy.

It is our policy to collect your co-payments, co-insurances, and/or any unmet deductible amounts from you at the time of service. In the event that a check is returned for Non-Sufficient Funds, a $25.00 service fee will be charged to you.

We have verified your Physical Therapy/Occupational Therapy benefits with your insurance company, based on the information provided by you. Please be advised that your insurance company has the disclaimer that this is a verification of benefits only, and not a guarantee of payment. Benefits/payments are determined once the claim is received. We do not accept responsibility for the accuracy of the information provided by your insurance company. We recommend that you contact your insurance company directly if you have any further questions or concerns regarding your benefits.

The following is an **estimate** of the amount(s) you are responsible for and your benefits provided to us by your insurance company:

Co-pay per visit:	Co-Insurance per visit (estimate only):	Deductible: Amount Remaining:	Visit or Dollar Maximum:	Additional Information, if provided:

Please Note: Coverage information is provided as a courtesy to our patients, but is not intended to release them from total responsibility for their account balance. Any remaining balance due will be billed to you after additional information is received from your insurance company.

Please verify that you understand your financial responsibility by signing and dating this form:

I understand and agree that if I fail to make any of the payments I am responsible for in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

Patient/Guardian/Responsible Party Signature____ Date ____________

Clinic Representative ____ Date ____________

05/26/2016

CANCELLATION AND NO-SHOW POLICY:

Patient Responsibilities:

- If you are unable to keep your appointment, we expect you to call and cancel or reschedule that appointment.
- **You may be charged a $50 no-show fee if you fail to come to a scheduled appointment without calling prior to the scheduled appointment time to cancel or reschedule.**
- You are expected to arrive for your appointment on time. If you arrive more than 10 minutes late, Contact Physical Therapy reserves the right to reschedule your appointment. The no-show fee will NOT be charged to you in this instance.
- If you Cancel and/or "No Show" for 3 or more appointments in a row, you will be required to be seen by your referring physician before continuing physical therapy.

By signing here, I understand and agree to Contact Physical Therapy's cancellation and no-show policy.

____

Patient Name - Printed

______________________________________ ____________________

Patient (or Parent) Signature Date

Effective January 12th, 2015

CONTACT PHYSICAL THERAPY

PATIENT MEDICAL HISTORY

Patient Name: ______________________________ Onset date of illness/injury: ______________

Is this injury related to a motor vehicle accident? Yes No Primary Care Physician ________________

Referring Physician: ____________________________ Follow-up Visit Scheduled Date: ____________

Have you had surgery for this condition? Yes No Number of surgeries: __________

Type of surgery: ___________________________________

Are you currently taking any prescription or non-prescription medications? Yes No

Anti-inflammatory _____ List of Medications: ______________________________
Muscle Relaxers _____ (include dosage and ______________________________
Pain Medication _____ frequency & route) ______________________________

Please check if you have had any of the following medical/rehabilitative services for this injury/condition:

- ☐ CT Scan
- ☐ EMG/NCV
- ☐ MRI
- ☐ Myelogram
- ☐ X-Ray
- ☐ Other Diagnostic Test: ______________
- ☐ Chiropractor
- ☐ Emergency Room Care
- ☐ General Practitioner
- ☐ Massage Therapy
- ☐ Neurologist
- ☐ Occupation Medicine Doctor
- ☐ Occupational Therapy
- ☐ Orthopedist
- ☐ Physical Therapy
- ☐ Podiatrist
- ☐ Other: ______________

Please check if you have a history of any of the following:

- ☐ Anemia
- ☐ Asthma/Bronchitis/Emphysema
- ☐ Blood Clot/Emboli
- ☐ Cancer or Chemo/Radiation
- ☐ Diabetes
- ☐ Emotional/Psychological Problems
- ☐ Epilepsy/Seizures
- ☐ Heart Attack or Heart Surgery
- ☐ Heart Disease or Angina
- ☐ High Blood Pressure
- ☐ Infectious Disease
- ☐ Pacemaker
- ☐ Shortness of breath/chest pain
- ☐ Sleeping Problems/Disorders
- ☐ Stroke/TIA
- ☐ Thyroid Trouble/Goiter
- ☐ Tuberculosis
- ☐ Allergies
- ☐ Bowel or Bladder Problems
- ☐ Dizziness or Fainting
- ☐ Hernia
- ☐ Numbness or Tingling
- ☐ Severe or Frequent Headaches
- ☐ Varicose Veins
- ☐ Vision or Hearing Difficulties
- ☐ Weakness
- ☐ Weight Loss/Energy Loss
- ☐ Any Pins or Metal Implants
- ☐ Arthritis/Swollen Joints/Gout
- ☐ Back Injury/Surgery
- ☐ Elbow/Hand Injury/Surgery
- ☐ Joint Replacement
- ☐ Knee Injury/Surgery
- ☐ Leg/Ankle/Foot Injury/Surgery
- ☐ Neck Injury/Surgery
- ☐ Osteoporosis
- ☐ Shoulder Injury/Surgery

Are you pregnant? Y N

Have you had 2 or more falls in the last year or any fall with injury in the last year? Y N

Height ______________ Weight ______________

Is there any other information that you feel would assist us in your care? ______________________________

____

Are you aware of what your diagnosis is? Yes No

What are your goals while in this program? ______________________________

Patient/Guardian Signature: ______________________________ **Date:** ______________

I have reviewed this medical history with the patient: ______________________________
Therapist Signature

PATIENT INFORMATION SHEET

Name: ____ Date of Birth: _____________

Address: ____

____
City State Zip

Home Phone #: ____

Cell Phone #: ____

Email Address: ____

Would you like to receive our monthly newsletter with information on exercise, wellness, and nutrition, as well as prize giveaways?

Yes ☐ No ☐

(Please note that all contact information is for the use of this office only, and will not be given out or shared)

Emergency Contact Information:

Person to notify in case of emergency: ____

Phone #: __________________________ Relationship to patient: ____________________

****For Medicare patients only****

Have you received any Home Health Care within the past 60 days? ☐ Yes ☐ No

If yes, please list name of agency and discharge date: _______________________________

Was your injury due to any of the following: ☐ Auto Accident ☐ Work Comp ☐ Accident on property other than your own

Accident details: ____

Mesa: 4850 E. Baseline Rd, Suite 114, Mesa, AZ 85206 Phone: 480-396-2781, Fax: 480-854-3094
Scottsdale: 10304 N. Hayden Rd, Suite 120, Scottsdale, AZ 85258 Phone: 480-429-5266, Fax: 480-429-5297

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services (**Office for Civil Rights/U.S. Department of Health & Human Services)** if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, **Dallas Lato** at (480) 396 - 2781 **or contactphysicaltherapy.com** for further information about the complaint process.

This notice was published and becomes effective on **September 23 2013.**

ACKNOWLEDGEMENT (to be signed by patient)

I,____, hereby acknowledge that I have received and have had the opportunity to review the Notice of Privacy Practices.

Signature:____ Date:____________________

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO INDIVIDUALS INVOLVED IN PATIENT'S CARE:

Information about your health and health care is filed in your medical record. There may be times when it is necessary for an individual involved in your care to call this office to inquire about your personal health information or billing information. Please take a moment to complete this form regarding how you wish to have this information released.

Such persons involved in your care may include spouses, children, blood relatives, roommates, boyfriends/girlfriends, domestic partners, neighbors, and colleagues.

I wish to allow my health information to be disclosed to the following individuals involved in my care:

Name: Relationship:

Name: Relationship:

Name: Relationship:

I do NOT wish to allow my health information to be disclosed to the following individuals involved in my care:

Name: Relationship:

Name: Relationship:

Name: Relationship:

____ ____________________

Signature of Patient (or Patient's Representative) **Date**