

Please print clearly and sign below

Date: _____

Patient Name (Last) _____ (First) _____ (M.I.) _____

Birth Date _____ Sex: (M) (F)

Social Security# _____ of financially responsible party.

Drivers Lic # _____ (Only required if SS# not supplied)

Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____

Cell Phone (____) _____ How do you prefer to receive your statements: E-mail Fax Mail

E-mail _____ Fax (____) _____

Guarantor: _____ Occupation: _____

Address _____ Phone (____) _____

Social Security# _____

If the patient is a minor, please put social security number of the responsible party.

*******DIVORCE SITUATIONS:*******

In cases of divorce, it is our policy that any amount left owed after insurance has been paid will be the responsibility of the *parent who brings the child for their appointments*. This is between you and your ex-spouse. We do not bill to anyone other than the parent who initiated the appointment and brings them for their appointments. No exceptions.

Is This Patient A Minor? YES NO

Referring Physician (if applicable) _____ Telephone _____

Who may we thank for your referral other than your Doctor? _____

Name of Parent : Mother _____ phone: _____

Father _____ phone: _____

Name and address of closest relative or friend in case of emergency:

Name: _____ Address: _____ City: _____ State: _____

Zip: _____ Phone: _____

INSURANCE INFORMATION (Please Complete)

Primary Insurance _____ Policy # _____

Cust. Service Phone # _____ Insured Name _____ D.O.B. _____

All professional services rendered are the ultimate responsibility of the patient.

Signature: _____ Date: _____

Patient Name _____ Age _____

Type of Injury / Condition _____

Onset / Injury Date _____

Type of Surgery & Date _____

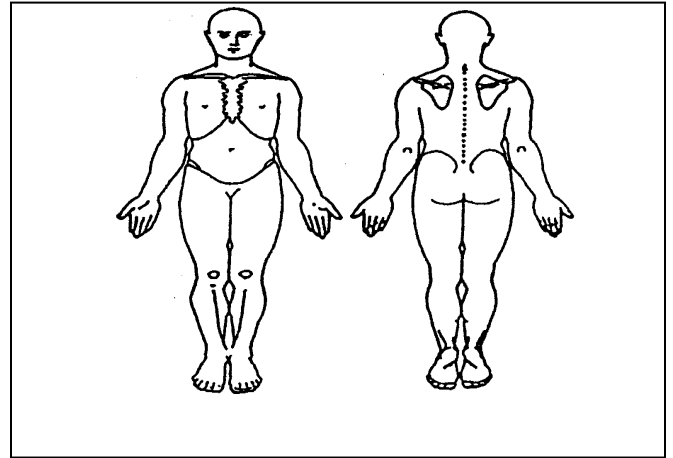
Next Doctor's Appointment? _____

Describe previous treatment for this condition _____

Have you received physical therapy treatment this year? Yes / No

Have you received speech therapy treatment this year? Yes / No

Have you received Home Health Care via Medicare this year? Yes / No



Have you had any imaging performed:

- X-Ray
- MRI
- CT Scan
- Doppler
- Ultrasound

Please mark the area(s) of concern

Have you recently noted:

- Weight Loss /Gain
- Weakness
- Pregnant / IUD
- Pain At Night
- Nausea / Vomiting
- Fever / Chills / Sweats
- Headaches
- Cramps In Legs When Walking
- Fatigue
- Numbness / Tingling
- Change In Vision Or Hearing
- Insomnia

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

- Surgeries
- Sprains / Strains
- Heart Problems
- Circulation Problems / Clots
- Easy Bruising / Bleeding
- Indigestion / Heartburn
- Any previous injury that may affect current care _____
- Loss of Consciousness
- Diabetes
- Cancer
- Asthma / Breathing Problems
- Leg / Ankle Swelling
- Fainting
- Fractures
- Blood Pressure Problems
- Motor Vehicle Accident
- Lung Disease
- Urinary Problems / Infections
- Allergies / Skin Sensitivity

Explain & give approximate dates for any items indicated above _____

Are you currently taking medications? Yes / No Name or Type of Medication _____

Type Of Pain: Sharp / Burning / Aching / Tingling / Numbness / Other _____

Rate your pain (1=minimal 10=severe): At it's worst: 1 2 3 4 5 6 7 8 9 10 / At it's best: 1 2 3 4 5 6 7 8 9 10

What do you hope to get out of your treatment? _____

What are your physical or fitness goals: _____

Is there anything else you would like to include or ask your physical therapist? _____

Patient or Personal Representative Signature _____

Date _____

Financial Policy: As a courtesy, we will bill the primary insurance company for our patients, if we are provided the necessary information. This also includes Personal Injury Protection claims (PIP) and the state (L&I or private Worker’s Compensation, Medicare and Medicaid). Co-payments are due at the time of each visit. It is important to communicate any financial problems as soon as possible. All patient balances must be paid within three (3) months of the last date of service, unless an approved payment plan has been created. Please contact the business office directly to discuss a mutually agreeable payment plan so you will not jeopardize your credit. If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us. In the event of non-payment and/or no payment plan, formal collections procedures may become necessary and you will be responsible for an additional 30% due to collection agency costs.

Your insurance is a contract between you, your employer (if necessary), and your insurance company. We are not a party to that contract. Therefore, it is the patient’s responsibility to determine what their insurance company allows for therapy, obtain prior approval (if necessary) and follow up with their insurance company on all unpaid visits.

Should your insurance deny payment or coverage for any reason, you are responsible for any and all charges billed. A statement will be mailed to you after the denial has been received from your insurance company. This notice will hold for duration of your treatment for this injury. These denials may include, but are not limited to:

- Medical Necessity
- Required Documentation Missing
- Investigational Coding
- Processing Dispute
- Exceeds Plan Limits
- Preauthorization not obtained by patient or by Total Sports Therapy

WORKERS’ COMPENSATION CLAIMS: If you claim Workers’ Comp benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered.

Patient Consent and Release: I understand that I am financially responsible for all charges for service rendered regardless of litigation, insurance reimbursement, or pending L&I claims. I understand the parent accompanying a minor for treatment will be responsible for payment. I request and consent to the performance of evaluation, treatment and procedures. I understand that I am free to withdraw my consent and that I may stop treatment or any procedure at any time.

I authorize Total Sports Therapy to release any necessary information requested by my insurance carrier and authorize payment directly to Total Sports Therapy for any benefits available under my insurance plans.

NO-SHOW POLICY: We require at least same day notice in the event of a cancellation. The charge for a no-show without notice prior to scheduled visit is \$25. This charge will not be covered by insurance, but will have to be paid by you personally. Patients that are over 15 minutes late for their appointment will be considered a NO-SHOW, regardless if a phone call stating they are going to be late was made. Effort will be made to still see the patient, but there is no guarantee the therapist will have the time. Rescheduled no-show appointments must be attended to avoid the no-show fee.

Patient (non-minors)/Guardian/Responsible Party

Date

Co-Pay	Co-Insurance
<div style="border: 1px dashed black; display: inline-block; padding: 2px;">Estimated</div> Co-Pay \$ _____/visit We will collect your co-pay on the last visit of each week.	<div style="border: 1px dashed black; display: inline-block; padding: 2px;">Estimated</div> Co-Insurance \$ _____/visit Deductible \$ _____/year We will collect you estimated co-insurance or deductible at the last visit of each week.

NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.**

Summary:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This **Notice** describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to request corrections to your information;
2. The right to request that your information be restricted;
3. The right to request confidential communications;
4. The right to a report or disclosures of your information; and
5. The right to a paper copy of this Notice

We want to assure you that your medical/protected health information is secure with us. This **Notice** contains information about how we will insure that your information remains private. If you have any questions about this **Notice**, the name and phone number of our contact person is listed on this page.

Drew Giardina, Director of Outpatient Physical Therapy
(480) 272-7140

Acknowledgement of Notice of Privacy Practices

"I hereby acknowledge that I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES**. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me updates to this **NOTICE OF PRIVACY PRACTICE** should it be amended, modified, or changed in any way."

Patient or Representative Name (please print)

Patient or Representative Signature

Date

Patient Refused to Sign

Patient Was Unable to Sign Because
