

PATIENT MEDICAL HISTORY

Name: _____ Referring Physician: _____

Family Physician: _____ Date first seen for this injury: _____

Have you had surgery for this injury? Yes No Number of surgeries: 1 2 3 4 _____

Type of surgery: _____

List your current prescription or non-prescription medications:

Pain Meds _____ Muscle relaxers _____ Anti-inflammatory _____

Others _____

Have you had any of the following medical or rehabilitative services for this injury or episode?

	YES	NO		YES	NO
Physical Therapy	_____	_____	MRI	_____	_____
Massage Therapy	_____	_____	X-Rays	_____	_____
Chiropractic	_____	_____	CT Scan	_____	_____
Podiatrist	_____	_____	EMG/NCV	_____	_____
Neurologist	_____	_____	Myelogram	_____	_____
Orthopedist	_____	_____	Injections	_____	_____
Other _____					

Do you NOW have ANY of the following?

	YES	NO		YES	NO
Asthma, Bronchitis or Emphysema	_____	_____	Severe or frequent headaches	_____	_____
Shortness of breath/chest pain	_____	_____	Numbness or Tingling	_____	_____
High Blood Pressure	_____	_____	Dizziness or Fainting	_____	_____
Epilepsy/Seizures	_____	_____	Bowel or Bladder Problems	_____	_____
Thyroid disease or Goiter	_____	_____	Weakness/Energy loss	_____	_____
Anemia	_____	_____	Weight loss/gain	_____	_____
Diabetes/Type _____	_____	_____	Any pins or metal implants	_____	_____
Arthritis/Where _____	_____	_____	Emotional/Psychological	_____	_____
Osteoporosis	_____	_____	Are you Pregnant	_____	_____
Sleeping difficulties	_____	_____	Do you Smoke?	_____	_____

Have you EVER had any of the following?

	YES	NO		YES	NO
Coronary heart disease or Angina	_____	_____	Vision or Hearing Difficulties	_____	_____
Do you have a pacemaker	_____	_____	Hernia	_____	_____
Heart Attack/Surgery	_____	_____	Varicose Veins	_____	_____
Stroke/TIA	_____	_____	Allergies	_____	_____
Congestive heart disease	_____	_____	Joint replacement surgery	_____	_____
Blood clot/Emboli	_____	_____	Neck injury/surgery	_____	_____
Infectious Disease	_____	_____	Back injury/surgery	_____	_____
Cancer/Type _____	_____	_____	Shoulder injury/surgery	_____	_____
Gout	_____	_____	Knee injury/surgery	_____	_____
Ankle/foot injury/surgery	_____	_____	Elbow/hand injury/surgery	_____	_____

List any other information that would assist us in your care: _____

Do you feel you have been made aware of your diagnosis? YES NO Based on your awareness, what are your Goals and expectations from physical therapy? _____

Patient/Guardian: _____

Date: _____

Northwest Orthopedic & Sports Physical Therapy, LLC

PATIENT DATA SHEET

Date : _____

Social Security #: _____ - _____ - _____

Account #: _____

Patient's Name: _____
Last First MI

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone (_____) _____ - _____ Day Phone: (_____) _____ - _____

Email address : _____ How did you hear about our office : _____

Date of Birth: _____ / _____ / _____ Sex: M F Marital Status: M S D W

Employment status : ___ Full Time ___ Part Time ___ Student ___ Retired

Employer: _____ Job Title: _____

Address: _____

Work Phone: (_____) _____ - _____ Current work status: _____

Description of job tasks: _____

Emergency Contact (Someone not living in household): Relationship: _____ Phone #: (_____) _____ - _____

Name / Address: _____

INSURANCE INFORMATION

Verified : _____

Primary Insurance: _____ Phone #: (_____) _____ - _____

Policy/Claim #: _____ Group #: _____

Primary Insured: _____ Phone #: (_____) _____ - _____

SSN: _____ - _____ - _____ DOB: _____ / _____ / _____ Relationship: _____

Secondary Insurance: _____ Phone #: (_____) _____ - _____

Policy/Claim #: _____ Group #: _____

Northwest

Orthopedic and Sports Physical Therapy, LLC 14800 W Mountain View Blvd. #260 Surprise, Arizona 85374 (623) 556-5013 Fax (623) 556-9290

NOTICE OF PRIVACY PRACTICES

As required by the Privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA), our office offers you, our patients this notice of privacy practices. The notice describes how health information about you as a patient of our office may be used and disclosed and how you can get access to your protected health information (PHI). Please read the notice carefully. In summery it describes the following:

- 1) Our offices' commitment to your privacy.
- 2) How your PHI is used and disclosed by our office.
- 3) Your rights as a patient and how you can have access to your PHI.
- 4) Our responsibilities according to the law.

If you have any questions regarding this notice or the health information privacy policies of this office, please contact Scott Peterson, Director of Northwest Orthopedic and Sports Physical Therapy, LLC at the above address and phone number.

I hereby acknowledge that I have been presented with a copy of Northwest Orthopedic and Sports Physical Therapy's Notice of Privacy Practices.

Patient's Name : _____
Please Print

Patient/Guardian Signature: _____

Date: _____

Northwest

Orthopedic & Sports Physical Therapy

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for NORTHWEST ORTHOPEDIC & SPORTS PHYSICAL THERAPY, LLC to furnish medical care and treatment to _____ considered necessary and proper in diagnosing and treating their physical and mental condition.

Patient/Guardian: _____ Date: _____

CANCELLATION POLICY

Your physician has referred you to physical therapy because he/she believes that it can be of great benefit in your recovery. Therefore consistent attendance for your planned therapy treatments is extremely important. At Northwest Orthopedic and Sports Physical Therapy we strive to provide each patient with the highest quality care while attempting to accommodate everyone's busy schedule. In order to minimize waiting time and to assure continuity of treatment, we try to provide time slots for each patient with the therapist.

When you cancel an appointment at the last minute, or fail to show at all, our ability to accommodate the scheduling need of others is severely limited. Therefore, we ask your cooperation with the following policy:

- ⑥ If you are unable to keep a scheduled appointment, please notify us no later than the prior working day (before 5:00p.m.) so that your appointment time slot can be rescheduled.
- ⑥ If you are an industrial patient whose therapy is covered by a worker's compensation carrier, we are required to notify your case manager if you cancel an appointment or do not reschedule, or if you fail to keep a scheduled appointment.

We appreciate your cooperation and consideration for our staff and other patients. Thank you in advance.

Acknowledgment of Cancellation Policy

Patient/Responsible Party: _____ Date: _____

ASSIGNMENT OF BENEFITS

I authorize and assign the direct payment to you of any sum I now or hereafter owe you, by my attorney, out of proceeds of any settlement of my case, and by any insurance company obligated to reimburse me for the charges for your services or otherwise obligated to make payments to me or you based in whole or in part upon the charges made for your services.

I give assignment and lien against any claims against a third party whose negligence may have caused the patient's injury, up to the amount of the bill for treatment.

In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges incurred for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of actions that exists in my favor against any such company (name(s) of which is believed to be correctly set forth under pertinent data below) and authorize you to prosecute said action either in my name or your name as you see fit. Further, I authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company (or companies) contractually obligated, you will refrain from attempts and efforts to collect the amounts you do not collect from insurance proceeds (whether it be all or part of the sums due) I personally owe you.

I waive the Statute of Limitations regarding my healthcare provider's right to recover.

I understand that I am responsible for payment of services not otherwise covered by my health benefits plan. Further, I agree to pay for such services under the policy set forth by the provider. Furthermore, I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney, I will be responsible for all costs of collecting moneys owed, including court costs, collection fees and attorney fees.

I have read the above information and I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Patient or Responsible Party

Date

Clinic Representative

Date