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 -inflammatories** _____
Others _____

Have you hand 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 : _____

Patient's Name: _____
Last First Middle Initial

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

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

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

Date of Birth: _____ / _____ / _____ **Age:** _____ **Height:** _____ **Weight:** _____

Social Security #: _____ - _____ - _____ **Marital Status:** **M** **S** **D** **W** **Sex:** **M** **F**

Have you had two or more documented falls in the past year, or any fall with injury in the past year? Yes / No

Employment status: ____ **Full Time** ____ **Part Time** ____ **Student** ____ **Retired**

Employer: _____ **Job Title:** _____

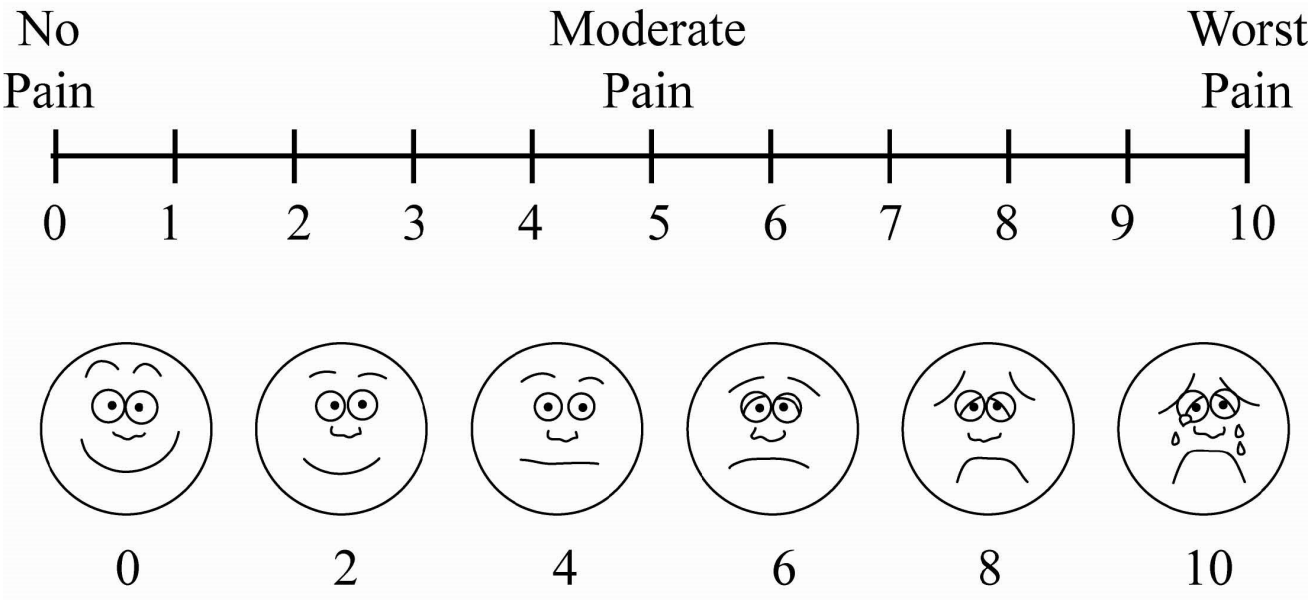
Address: _____

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

Description of job tasks: _____

Emergency Contact (Someone not living in household): Name: _____

Phone #: (_____) _____ - _____ **Relationship:** _____



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:

- 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.

- 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 waiver 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