Previous Patient? Y / N

Reason for today's appointment: ___________________________ Date: ______________________

Date of Injury: __________________

Date of Birth ______/______/______ Social Security # ______-_______-________

Last Name ____________________________ First Name ____________________________ MI______ Nickname_____________

Street Address ____

City _________________________________State _______________Zip _____________

Telephone: Home (______) _______-________ Cell (______) _______-________

E-Mail for Appointment Reminders: ____

Emergency Contact _________________________________ Phone (_____) ______-_________

****Have you had physical therapy/chiropractic/occupational therpay prior to coming to Phoenix?** YES / NO

****Have you been in or will be in any Home Health** YES / NO **Start Date: ______________ End Date: _______________**

*******<u>Responsible Party *(If different from above)*</u>*******

Name:___________________________DOB:________________Social Security #___________________Relationship:_____________

Address:____

Home#: (________) __________-____________ Cell#: (________) _________-____________

Do you have an HRA ____ or HSA ________

Today's visit related to a <u>worker's comp injury</u>: YES / NO Date of injury: ______________________

Today's visit related to an auto accident? YES / NO Date of accident:_____________________

I acknowledge that the information stated above is true. I authorize that payment of any insurance benefits for health care services or goods may be made directly to *PHOENIX PHYSICAL THERAPY AND SPORTS PERFORMANCE, LLC*. I also acknowledge by signing below I hereby accept the terms and agreements made by the attached *PHOENIX PHYSICAL THERAPY AND SPORTS PERFORMANCE, LLC*-Patient Registration and Consent for Medical Treatment Form.

________________________________ ________________ ________________
Patient/Responsible Party Signature **Relationship** **Date**

PHYSICAL THERAPY AND SPORTS PERFORMANCE, LLC
290 North Hwy 16
Denver, NC 28037

MEDICAL INTAKE FORM

Patient: ________________________________ *Date of Birth*: ________________________

MEDICAL INFORMATION: TO THE BEST OF YOUR KNOWLEDGE, DO YOU HAVE / HAVE HAD :

1. High Blood Pressure	yes	no
2. Heart Disease Heart Attack	yes	no
3. Chest Pains / Angina	yes	no
4. High Cholesterol	yes	no
5. Pacemaker	yes	no
6. Shortness of Breath	yes	no
7. Asthma	yes	no
8. Allergies	yes	no
9. Chronic Bronchitis	yes	no
10. Blood Disorders	yes	no
11. Emphysema	yes	no
12. Bleeding/Bruising	yes	no
13. Anemia	yes	no
14. Diabetes	yes	no
15. Hypoglycemia	yes	no
16. Lightheadedness	yes	no
17. Dizziness	yes	no
18. Concussion	yes	no
19. Fainting Disorders	yes	no
20. Anxiety/Panic Attacks	yes	no
21. Arthritis/Joint Pain	yes	no
22. Artificial Joints	yes	no
23. Kidney Disease/Stones	yes	no
24. Hepatitis-Please indicate: A / B / C	yes	no
25. Spinal Cord Injury	yes	no
26. Traumatic Brain Injury	yes	no
27. Ulcers	yes	no
28. Blood in Stool / Ulcers	yes	no
29. Abdominal Pain	yes	no
30. Thyroid Problems	yes	no
31. Polio/ Muscle Disease	yes	no
32. Seizures	yes	no
33. Migraine/Cluster Headaches	yes	no
34. TMJ Disorders	yes	no
35. Chills/Fever/Sweats	yes	no
36. Chronic Headaches	yes	no
37. Swelling of Extremities	yes	no
38. Sleep Disorders	yes	no
39. Depression	yes	no
40. Fibromyalgia	yes	no
41. Chronic Fatigue Syndrome	yes	no
42. Lyme’s Disease	yes	no
43. Chronic Pain	yes	no
44. Night Pain	yes	no
45. Unexplained Pain	yes	no
46. Unexplained Weight Loss	yes	no
47. Cancer/Tumors/Growths	yes	no
48. History of Smoking	yes	no
49. Are you pregnant?	yes	no
50. Gynecological Disorders	yes	no
51. Bladder Incontinence	yes	no
52. Bowel Incontinence	yes	no
53. Fractures	yes	no
54. Stroke	yes	no
55. Alzheimer	yes	no
56. Parkinson Disease	yes	no

CURRENT MEDICATIONS:____

ALLERGIES:

A. To Medications:____

B: To Other Substances:____

SURGERY (S) Include Dates:____

X-RAYS, MRI, CAT SCANS (Include Area & Dates): ______________________________

SIGNATURE: ____ Date:______________________

PHOENIX PHYSICAL THERAPY AND SPORTS PERFORMANCE, LLC
Patient Registration and Consent for Medical Treatment/Release

1. **Consent for Health Care Services**: I authorize consent for medical treatment at ***PHOENIX PHYSICAL THERAPY AND SPORTS PERFORMANCE, LLC***
2. **Authorization for Release or Information:** ***PHOENIX PHYSICAL THERAPY AND SPORTS PERFORMANCE, LLC*** may release information from my medical records to any health care provider involved in my care and treatment. ***PHOENIX PHYSICAL THERAPY AND SPORTS PERFORMANCE, LLC may*** also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, the Medicare programs, and my employer's workers' compensation carrier. I acknowledge that upon the disclosure of medical record information to an insurance company or other payer pursuant to this authorization, ***PHOENIX PHYSICAL THERAPY AND SPORTS PERFORMANCE, LLC*** is no longer responsible for the confidentiality of any information known or possessed by the payer.
3. **Preauthorization Requirements:** I accept the responsibility to obtain all referrals or pre-authorizations and to comply with all requirements of any insurance or medical coverage plan upon which I am relying for medical coverage of ***PHOENIX PHYSICAL THERAPY AND SPORTS PERFORMANCE, LLC*** charges.
4. **Assignment for Direct Payment**: I authorize that payment of any insurance (including auto insurance and health-care insurance) benefits for health care services or goods may be made directly to ***PHOENIX PHYSICAL THERAPY AND SPORTS PERFORMANCE, LLC charges*** not paid.
5. **Charge for Cancellation without 24 hour notice & No Show:** I understand if I do not cancel my appointment at least 24 hours in advance, I will be charged $25.00 fee. For any appointments I No Show, I will be charged $35.00 fee. I also understand that I will be responsible for this charge as this is not covered by my insurance company.

CONSENT OF TREATMENT

I hereby authorize ***Phoenix Physical Therapy & Sports Performance, LLC*** through its appropriate personnel, to furnish medical care and treatment to me, or the above named patient, considered necessary and proper in diagnosing or treating my/his/her physical condition.

AUTHORIZATION TO RELEASE INFORMATION

I further authorize ***Phoenix Physical Therapy & Sports Performance, LLC*** to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment necessary to secure payment for services provided.

I acknowledge that:

- I have read this form and understand its contents.
- I am the patient, or person duly authorized either by the patient or otherwise, to sign this agreement, consent to, and accept its terms.
- I have received a copy of PHOENIX PHYSICAL *THERAPY AND SPORTS PERFORMANCE, LLC* HIPAA Policy.

____________________________________ ______________________________

Signature of Patient or Legally Responsible Person **Name (PRINT)**

____________________________________ ______________________________

Relationship/Reason Why Patient is Unable to Sign **Date**

Statement of Financial Responsibility & Disclosures

Phoenix Physical Therapy & Sports Performance, LLC appreciates the confidence you have shown in choosing us to provide for your rehabilitative needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill.
You are responsible for payment of any co-payment at the time of service and for any deductible /coinsurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full. If Payment is not made within 90 days from the date the statement was mailed from ***Phoenix Physical Therapy And Sports Performance, LLC,*** a delinquent charge of interest rate of 18% may be added to your bill. For the collection of any debt you will be reasonable pay all legal expenses necessary for the collection of any debt. For any credit or refund that you may be owed will be forwarded to the address on file with ***Phoenix Physical Therapy And Sports Performance, LLC.*** Any returned checks you will be responsible for a **$35.00** returned check fee in addition to any other associated bank charges.

I acknowledge that: I have read the above policy regarding my financial responsibility to ***Phoenix Physical Therapy & Sports Performance, LLC*** for providing rehabilitative services to the above named patient or me. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to ***Phoenix Physical Therapy & Sports Performance, LLC***. I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay ***Phoenix Physical Therapy & Sports Performance, LLC*** the full and entire amount of all bills incurred by me or the above named patient, if applicable, any amount due after payment has been made by my insurance carrier. **I am responsible for the payment and/or Co-Payment/Coinsurance/Deductible that are due.** I understand all charges are due and payable within **90 days** of the statement date. I understand that a delinquent charge of interest rate of **30%** may be added to my bill. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I understand that any credit or refund that I may be owed will be forwarded to the address on file with ***Phoenix Physical Therapy And Sports Performance, LLC.***
I understand that I am responsible for a **$35.00** returned check fee in addition to any other associated bank charges.

Signature: ____ **Date**: __________

(Relationship to patient: self - guardian - other: ____)

BILLING DISCLOSURES TO INDIVIDUALS INVOLVED IN PATIENT'S CARE

There may be times when it is necessary for an individual directly involved in your care to call the facility to inquire about your personal health information or billing information. Please take a few moments to complete this section.
I authorize ***Phoenix Physical Therapy & Sports Performance, LLC*** to disclose my health information that is directly related to my current treatment at Phoenix Physical Therapy to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received.

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

NAME: ____ RELATIONSHIP: ____________________________

OR

I do not wish to have my health information disclosed to individuals Not involved in my care.

Signature: ____ _____ **Date**: ______________

(relationship to patient: self - guardian - other: ____)

RULES & FEES

Please sign at the bottom of the page stating you have read and are aware of our fees.

<u>*IF YOU ARE 10 or MORE MINUTES LATE WE WILL HAVE TO RESCHEDULE YOUR APPOINTMENT***</u>**

1. **Only** clients are allowed in the treatment rooms and gym unless the client is a minor or requires special assistance.
2. All patients and/or clients **under the age of 18** needs to be accompanied by a parent or legal guardian to their first visit.
3. Please **No cell phones** during your physical therapy sessions, unless for emergencies.
4. A <u>$25</u> charge will be assessed for **All cancellations made within 24 hours of appointment.**
5. A <u>$35</u> charge will be assessed for **All No Shows.**
6. A <u>$35</u> charge will be assessed for **All Returned Checks.**

-Thank you for your cooperation-

______________________________ ____________

Patient/Responsible Party Signature **Date**

PROVIDER NOTICE OF PRIVACY PRACTICES

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

Uses and Disclosures: We use health information about you for treatment, billing, and healthcare operations. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred, for in-house marketing, for appointment verification, and with workers' compensation case workers. Information may be shared by paper mail, telephone, electronic mail, fax, or other methods. We may use or disclose identifiable health information about you without your authorization in several situations, but beyond those situations, we will ask for your written authorization before using or disclosing any identifiable health information about you.

Your rights: In most cases, you have the right to look at or get a copy of health information about you. If you request copies, we may charge you a fee. You also have the right to receive a list of certain types of disclosures of your information that we made. If you believe that information in your record is incorrect, you have the right to request that we correct the existing information.

Our legal duty: We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and seek your acknowledgement of receipt of this notice. If we make a significant change in our policies, we will change our notice and post the new notice in the waiting area.

You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints: If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

If you have any questions or complaints, please contact:
Privacy Officer: Tatum Robinson
Phoenix Physical Therapy & Sports Performance
Address: 290 North Highway 16
Denver, NC 28037
Phone: (704) 483-0777

……………………………………………………………………………………………

Acknowledgement of receipt of Notice of Privacy Practices:

Please sign your name and print your name and date on this acknowledgement form.

I acknowledge that the Notice of Privacy Practices is posted at the location in which I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have the right to request a copy of the notice and one will be provided to me.

Patient Signature: ____________________________________Date: _______________

Printed Name: ____

Patient Representative/Legal Guardian, if applicable: ____________________________