THE PHYSIOFIX PATIENT INTAKE FORM

Please complete all pages of this form and then either email it to office@thephysiofix.com, fax to (949) 553-3561, or bring it in to us at your first session. If you have any questions, please call us at (602) 734-5610. Thank you!

PATIENT INFORMATION

Patient Email Address:			Today's Date:			
Patient's Last Name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital Status (circle one): Single / Married / Divorced / Separated / Widowed	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Former name(s):	Birth date: / /	Age:	Sex: ❑ M	❑ F
Street Address:		Social Security #:	Cell Phone #: ( )			
P.O. Box:	City:	State:	ZIP Code:			
Occupation:	Employer:	Employer Phone #: ( )				
Referred to or chose our clinic because (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital			
❑ Family	❑ Friend	❑ Close to home/work	❑ Web search	❑ Other		
Other family members seen here:						

INSURANCE INFORMATION

Please give your insurance card to the front desk staff.

Person responsible for bill:	Birth date: / /	Address (if different):	Home Phone #: ( )		
Is this person a patient here?	❑ Yes ❑ No				
Occupation:	Employer:	Employer address:	Employer Phone #: ( )		
Is this patient covered by insurance?	❑ Yes ❑ No				
Primary insurance name/plan					
Subscriber's Name:	Subscriber's SSN.:	Birth date: / /	Group #:	Policy #:	Co-payment: $
Patient's relationship to subscriber:	❑ Self ❑ Spouse	❑ Child	❑ Other:		
Name of Secondary Insurance (if applicable):	Subscriber's Name:	Group #:	Policy #:		
Patient's relationship to subscriber:	❑ Self ❑ Spouse	❑ Child	❑ Other		

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home Phone #: ( )	Work Phone #: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize The Physio Fix or insurance company to release any information required to process my claims.

Patient/Guardian Signature _____ *Date* _____

THE PHYSIOFIX HEALTH HISTORY QUESTIONNAIRE

Please fill out this form in its entirety to assist your physical therapist in developing the best plan of care for you. If you have any questions, don't hesitate to ask for assistance. The information collected here will remain confidential unless authorized for release by the patient.

Patient Name: _____ Date of Birth: _____/_____/_____

Occupation: _____ Hobbies: _____

Date of Injury (if applicable): _____/_____/_____ Gender: _____

Circle whether your injury was SUDDEN ONSET or GRADUAL ONSET

Has this injury prevented you from working? Circle one: YES NO

If yes, how long have you been out of work? _____

Regarding your work status, at the **PRESENT TIME** I can:

_____Work without restrictions
_____Work the same job with restrictions
_____Work a different job with restrictions
_____Unable to work due to dysfunction
_____Don't normally work outside the home
_____Homemaker
_____Retired
_____Other

Is there a case for the injury that involves an attorney? Circle one: YES NO

If yes, please provide the ATTORNEY NAME: _____ PHONE #: _____

Have you sought previous treatment for this condition?

_____No other treatment
_____Physical/Occupational Therapy
_____Chiropractor
_____ Massage Therapy
_____Psychiatrist/Psychologist
_____Other: _____

List any prescription medications you are taking, including injections and skin patches:

_____

_____

List any over-the-counter medications you are taking, including vitamins and supplements:

_____

_____

List any surgeries or other conditions for which you have been hospitalized:

Date of Surgery/Hospitalization	**Type of Surgery/Reason**
_____	_____
_____	_____
_____	_____
_____	_____

Please check any of the following symptoms that you are currently having or have experienced in the past 3 months:

_____Fever
_____Chills
_____Skin Rash
_____Pins/Needles
_____Numbness
_____Night Sweats
_____Vision Problems
_____Hearing Loss
_____Shortness of Breath
_____Headaches
_____Bowel/Bladder Problem

THE PHYSIO FIX HEALTH HISTORY QUESTIONNAIRE

Please check any of the following conditions that apply to you either currently or in the past:

_____High Blood Pressure _____Chest Pain/Heart Attack _____Stroke _____Gout
_____Heart Disease _____Cardiovascular Disease _____Allergies _____Asthma
_____Epilepsy/Seizures _____Kidney Disease _____Hepatitis _____Arthritis
_____Tuberculosis _____Varicose Veins _____Depression
_____Lung Disease _____Hearing Loss _____Thyroid Problems
_____Dizziness/Fainting _____Emphysema/Bronchitis _____Emotional/Psychological Problems
_____Chemical Dependency (alcohol/drugs)
_____Other: _____

Are you aware of your current diagnosis? Circle one: YES NO

Do you have questions regarding your diagnosis or prognosis? Circle one: YES NO

Note any other comments or concerns you have: _____

_____

PAIN LEVEL ASSESSMENT: Scale from **0/zero = no pain** to **10/ten = the worst pain you have ever experienced**

My current pain level is a _____.

Throughout the day, my pain ranges from a _____ to a _____.

Describe the location of your pain (body part, front/back/side, etc.):

_____

Describe the type of pain (dull, sharp, stabbing, achy, tender, tight, etc.):

_____

My pain gets better when I: _____

My pain gets worse when I: _____

ADDITIONAL QUESTIONS:

Have you ever been treated at The Physio Fix? Circle one: YES NO

If yes, when? _____ Patient Name: _____

Have you had physical therapy, occupational therapy, or chiropractic treatment this year? Circle one: YES NO

If yes, please indicate the type of treatment and the duration of treatment? _____

_____

Have you previously had physical therapy for this condition? Circle one: YES NO

If yes, for how long? _____

<u>For Medicare Patients Only</u>:

Are you currently receiving home care services? Circle one: YES NO

If yes, when will you be completely done with home care? _____

Do you have a home care discharge letter? Circle one: YES NO

<u>For Student-Athletes Only</u>:

What sport(s) does the student-athlete play? _____

Was the student athlete injured during the performance of the sport? Circle one: YES NO

If yes, what date was the student athlete hurt? _____

Was the student athlete hurt at school or in a league? Circle one: SCHOOL LEAGUE NOT APPLICABLE

If yes, was any paperwork filed with the school or league? Circle one: YES NO

Name of School or League: _____

THE PHYSIOFIX

PATIENT/GUARDIAN GENERAL ACKNOWLEDGMENTS

The following items represent important general information you need to be aware of as a patient of The Physio Fix. There are additional forms for specific office policies that require more details and explanation. All forms and policies must be reviewed and signed by your first appointment.

Financial Responsibility: *(See FINANCIAL POLICY for more detail)*

☐ I understand that I am responsible for any balance due and owing to The Physio Fix for services rendered. I agree to pay The Physio Fix all amounts that are due and owing for services provided that are not otherwise paid for by Medicare, a third-party insurance plan, a third-party payor, or other payor sources on my behalf for services rendered. In the event this account is referred to a collection agency or an attorney, the undersigned further agrees to pay all reasonable costs of collection including, but not limited to, reasonable attorney's fees.

Disclosure of Personal Information: *(See NOTIFICATION & DISCLOSURE POLICY for more detail)*

☐ I acknowledge that The Physio Fix may disclose protected health information for the purposes of payment, treatment, and healthcare operations.

Consent to Treatment: *(See also CONSENT TO TREAT A MINOR form as needed)*

☐ I consent to receive outpatient rehabilitation therapy services and any ancillary services that are deemed medically necessary or appropriate by my physical therapist and/or treating physician. However, I am aware that the practice of rehabilitation therapy is not an exact discipline and I acknowledge that no guarantees have been made to me regarding treatment and the treatment results from the rehabilitation therapy.

Newsletter:

To provide our patients with a high level of customer service and the latest information about our clinic, you may periodically receive emails from our company and its affiliates.

Select one: ☐ Yes, email me ☐ No, I opt-out

Dogs in Facility:

☐ I acknowledge that The Physio Fix owner has multiple friendly dogs that may be present in the facility at any time. They can be caged upon request. I understand that I must call the clinic before arriving for my appointment to request this.

Notification of Additional Policies/Forms not mentioned above that are provided & required:

☐ Appointment Policy

☐ Authorization for Photo/Video/Audio/Interview Form

☐ Authorization for Student Participation Form

Signature of Patient or Guardian: _____ *Date Signed:* ___ /___ /_____

Printed Name: _____ Patient Name: _____

THE PHYSIOFIX

CONSENT TO TREAT A MINOR

Minor Patient Name: _____ Minor Date of Birth: ___ /___ /_____

The undersigned does hereby provide *The Physio Fix* staff with consent to examine and treat the above-mentioned minor <u>without</u> a Parent or Guardian present.

Important Medical Information (Allergies, Medications, etc.):

_____

_____

_____

_____

Father/Guardian Signature: _____

Printed Name: _____

Mother/Guardian Signature: _____

Printed Name: _____

Witness Signature: _____

Printed Name: _____

Date Signed: ___ /___ /_____

THE PHYSIOFIX

NOTIFICATION & DISCLOSURE POLICY

NOTIFICATION:

In compliance with the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule and our Notice of Privacy Practices, The Physio Fix will not disclose your protected health information ("PHI") without your explicit authorization, except as permitted by law for the purposes of payment, treatment, and health care operations.

Furthermore, The Physio Fix will limit the use, disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. Therefore, The Physio Fix will only disclose your appointment information, such as reminders or cancellations, on an answering machine, voice mail, text message, or e-mail, unless you inform us otherwise. This notice refers to The Physio Fix as "us" and "our," and to the patient/guardian as "I," "my," "you," "your," and "yourself."

I, the undersigned, hereby authorize The Physio Fix to disclose my appointment information using the following methods of communication and I assume all responsibility for ensuring that the methods of communication that I indicated below are secure, with password protection used where applicable:

Answering Machine: ( ) _____ - _____

Voice Mail: ( ) _____ - _____

Text Message: ( ) _____ - _____

E-Mail: _____

Signature of Patient or Guardian: _____ *Date Signed:* ___ /___ /_____

Printed Name: _____ Patient Name: _____

DISCLOSURE:

If you choose to have your PHI communicated to individuals other than yourself, please accurately complete the information below and sign the authorization. You further agree to be responsible for notifying The Physio Fix if any of this information changes.

I, the undersigned, hereby authorize The Physio Fix to disclose my PHI to the person(s) named below:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Signature of Patient or Guardian: _____ *Date Signed:* ___ /___ /_____

Printed Name: _____ Patient Name: _____

THE PHYSIOFIX

FINANCIAL POLICY

Thank you for choosing The Physio Fix! Please *carefully* review our Financial Policy. It is important for you to have a thorough understanding of your physical therapy benefits and financial responsibilities. This Policy Agreement must be initialed, signed, and submitted by the initial appointment.

ACCEPTED FORMS OF PAYMENT *Acceptance Initials:* _____

While we accept payment for services in cash or by credit card, we require that a valid credit card be kept on file in your account. If you prefer to make payment for any copayments, deductibles, coinsurances, balances, and/or fees due to The Physio Fix in cash, please notify us and present it in accordance with the requirements listed below. If cash payment is not made accordingly, the credit card on file will be charged to collect any amounts due.

NO INSURANCE / SELF-PAY OPTIONS *Acceptance Initials:* _____

The Physio Fix offers a self-pay option and session packages to anyone – whether you don't have health insurance, don't want to use insurance, have reached your maximum insurance benefits, and/or have insurance that we do not accept.

We offer session packages in multiples of 5, 10, 20, 30, and 50. The greater the session count, the lower the per-session cost. Please ask our office staff for the current rates. Package sessions can be shared among friends and family. All package sessions must be used within 1 year from the date of purchase and are non-refundable.

MEDICAL INSURANCE COVERAGE *Acceptance Initials:* _____

The Physio Fix accepts Blue Cross Blue Shield health insurance plans (*other health insurance may be accepted on a case-by-case basis solely at the discretion of The Physio Fix*). Before your initial visit, we will do our best to gather the information needed to verify your current insurance coverage and benefits.

If you have not provided us with your insurance information before your first appointment, we have no way of verifying your benefits and you will be asked to pay the self-pay cash initial evaluation rate at the time of service. Once your benefits have been verified, the amount paid at the initial visit will convert to a credit on your account that can then be applied to the relevant co-pay or deductible. **NOTE: Verification of physical therapy benefits is NOT a guarantee of payment.**

It is ultimately your responsibility to know your physical therapy benefits and all costs are based on the insurance coverage in existence at the time of service.

CO-PAYMENT, DEDUCTIBLES, CO-INSURANCE *Acceptance Initials:* _____

As part of our contractual agreement with your insurance company, we must collect these fees directly from you. Often your annual deductible must be met before insurance will pay for physical therapy benefits. All co-payments, deductibles, coinsurances, and balances will be collected at the time of service. In addition, due to the growing trend towards high deductible plans, we will collect an estimated payment of $100 towards deductibles / $30 towards copays if your eligibility and benefit information cannot be determined by the time services are rendered. Please present payment upon arrival.

UNPAID BALANCES *Acceptance Initials:* _____

I understand that I am responsible for any balance due and owing to The Physio Fix for services rendered. I agree to allow The Physio Fix to charge the credit card on file in my account for all remaining balances after 30 days from the last date of service unless otherwise notified.

Account balances over 60 days without a payment or payment agreement will be subject to assignment to an out-of-office collection assistance agency. Should this be necessary, you will be charged a $25 transfer fee.

I have read, understand, and agree to the terms stated above. I recognize that I am financially responsible for the payment of my account to The Physio Fix regardless of my insurance coverage.

Signature of Patient or Guardian: _____ *Date Signed:* ___ /___ /_____

Printed Name: _____ Patient Name: _____

THE PHYSIOFIX

APPOINTMENT POLICY

Thank you for choosing The Physio Fix! Please *carefully* review our Appointment Policy. This Policy Agreement must be initialed, signed, and submitted by the initial appointment.

All in-person appointments are 1-on-1 with a Doctor of Physical Therapy for 1 hour. We plan in advance for your appointment and work hard to keep our schedules running on time. We know that emergencies and other circumstances may unknowingly arise, and we try to be accommodating where we can. Your cooperation and respect for the time and investment we make in providing top-notch physical therapy services are greatly appreciated! It allows us to help more people who are in pain.

CANCELLATIONS/RESCHEDULING

Acceptance Initials: _____

1) All appointment cancellations and rescheduling requests must be made using one of the following methods:
- calling our office at (602) 675-0325
- texting our office at (602) 634-5610
- emailing us at office@thephysiofix.com

2) All appointment cancellations and reschedules must be facilitated at least 48 hours in advance of your appointment to avoid a fee. The fee details are as follows:

a. Cancellations/reschedules made **between 24 and 48 hours** in advance of your scheduled appointment time will result in a **$75 fee** that will be collected by a charge to the credit card on file in your account at the time of the scheduled appointment.

b. Cancellations/reschedules made **less than 24 hours** in advance of your scheduled appointment will carry a **$125 fee** which is equivalent to a full appointment charge. If you have an active package of sessions, one session will be used in lieu of collecting fee payment. If you do not have an active package, this fee will be collected by a charge to the credit card on file in your account at the time of the scheduled appointment.

c. If a cancellation/reschedule request is made over the weekend, the date/time the request is received will be used to determine the applicable fee and will be charged to the credit card on file in your account when the determination has been made.

d. After three consecutive canceled/missed appointments the credit card on file will be charged in full for any outstanding balances and fees and rescheduling will be subject to management review.

NO-SHOWS

Acceptance Initials: _____

If you fail to show up for a scheduled appointment, you will be charged a **$125 fee** in accordance with item #2b above.

LATE ARRIVALS

Acceptance Initials: _____

If you are late for an appointment, you can use the remaining length of your appointment or you can reschedule for another day/time and be charged a **$125 fee** in accordance with item #2b, above.

I have read, understand, and agree to the terms stated above. I realize that I am financially responsible for any charges incurred from cancellations, late arrivals, and no-shows.

Signature of Patient or Guardian: _____ *Date Signed:* ___ /___ /_____

Printed Name: _____ Patient Name: _____

THE PHYSIOFIX

AUTHORIZATION FOR PHOTOGRAPHY, VIDEO, AUDIO, AND/OR INTERVIEW

I authorize to be interviewed, photographed, audio-taped, videotaped, and/or filmed (collectively called "Materials") by The Physio Fix staff or media representatives. The Materials may be used for publication, broadcast, medical instruction, patient education, electronic transmission (including digital media), or any other use The Physio Fix deems appropriate.

The purpose of this disclosure is to allow The Physio Fix representatives to record Materials for:

- The enhancement of patient care
- Dissemination of health education to the public
- Use in marketing/advertising

The Physio Fix staff will <u>not</u> condition treatment on whether I sign this authorization.

I release The Physio Fix, its staff, employees, and representatives from any and all liabilities which may arise from the use of Materials.

<u>PATIENT CARE</u>
I consent to receive transmission of the Material that is filmed during my treatment sessions from The Physio Fix or the treating physician via text, email, or other convenient messaging application, as an added benefit of my care.

<u>HEALTH EDUCATION & MARKETING/ADVERTISING</u>
I agree that any Materials taken shall be the sole and exclusive property of The Physio Fix and that they may use the Materials in any manner they wish, including dissemination to the public via any media. I also understand that my abbreviated name (first name and initial of the last name) and/or social media identity may also be used for these purposes.

I understand that information used or disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state law. The Physio Fix has the right to edit, modify and alter my image, likeness, statements, and recorded performance for use in the Materials.

I agree that the Materials will not be submitted to me for approval and that The Physio Fix will be without liability to me or others for the authorized use(s) of my image, likeness, statements, or recorded performance. I waive any right to inspect or approve the finished product, including written copy that may be created in connection with The Physio Fix's use and license rights herein.

I understand I will not be paid or receive any royalties. This agreement will be binding upon my survivors, heirs, descendants, administrators, executors, and all others who have or may have a legal claim or rights by my agreeing to this Release and License.

I understand that this authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Furthermore, I understand that this authorization will remain in effect unless specifically revoked by me. The revocation must be made in writing to The Physio Fix, 2103 W Parkside Lane, #103, Phoenix, AZ 85027.

Check one: ☐ I have read, understand, and agree to the terms stated above.
☐ I do **not** consent to be photographed, filmed, recorded, or interviewed.

Signature of Patient or Guardian: _____ *Date Signed:* ___ /___ /_____

Printed Name: _____ Patient Name: _____

THE PHYSIOFIX

AUTHORIZATION FOR STUDENT PARTICIPATION

The Physio Fix, which is owned and operated by Dr. Stacie Barber, PT, DPT, and located at 2103 W Parkside Lane, #103, Phoenix, AZ, 85027, participates in clinical education programs with colleges and universities to give students engaged in a course of study related to a medical career, including pre-medical students, medical students, interns, and residents ("students") experience in clinical practice.

Students are permitted to observe and participate in patient care activities, including, where appropriate, providing medical care to patients under a physician's direct supervision.

By signing below, I agree to permit the students working in The Physio Fix's facility to observe and participate in my medical care, including, where appropriate, providing direct medical care to me under a Physio Fix staff physician's direct supervision.

I agree that I have been given the opportunity to refuse to give such consent and that I may withdraw my consent at any time with written notification to The Physio Fix at the address listed above.

☐ **By checking this box, I <u>decline</u> student participation.**

Signature of Patient or Guardian: _____ *Date Signed:* ___ /___ /_____

Printed Name: _____ Patient Name: _____