ARIZONA MULTISPORTS PHYSICAL THERAPY
Wellness with Motion
Marlene C. Zuhl, PT, MS, MS
www.AZmultisportsPT.com

PAST MEDICAL HISTORY FORM

Patient Name ____________________

BLOOD PRESSURE	YES	NO
Hypertension	☐	☐
Low Blood Pressure	☐	☐

HEART DISEASE	YES	NO
Heart Attack	☐	☐
Atherosclerotic Disease	☐	☐
Myocardial Infarction	☐	☐
Rheumatic Heart Disease	☐	☐
Heart Murmur	☐	☐
Do you have a pacemaker	☐	☐

MUSCLE CONDITION	YES	NO
Carpal Tunnel R/L	☐	☐
Tennis Elbow R/L	☐	☐
Back/Neck Problems	☐	☐

LUNGS	YES	NO
Asthma	☐	☐
Emphysema	☐	☐
Shortness of Breath	☐	☐

JOINT CONDITIONS	YES	NO
Surgical Implants	☐	☐
Dislocation	☐	☐
Arthritis	☐	☐

OTHER CONDITIONS	YES	NO
Rheumatoid Arthritis	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy / Seizures	☐	☐
Gout	☐	☐
Fibromyalgia	☐	☐
Poor Eyesight	☐	☐
Fainting	☐	☐
Polio	☐	☐
Osteoporosis	☐	☐
Stroke	☐	☐
Previous Fractures	☐	☐
Previous Surgeries	☐	☐

Other: ____________________

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
☐ None	☐ Sitting	☐ Low	☐ Smoking	Packs a Day ____
☐ 1-2 x Week	☐ Standing	☐ Medium	☐ Alcohol	Drinks a Week ____
☐ 3-4 x Week	☐ Light Labor	☐ High	☐ Coffee/Soda	Cups a Week ____
☐ 5+ x Week	☐ Heavy Labor			

What types of exercise do you perform? : ____________________

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?

☐ YES ☐ NO If yes list name: ____________________

List all medications you are currently taking: ____________________

List all surgeries in the past two years (Including dates): ____________________

Are you pregnant? ☐ YES ☐ NO What week?: __________

Have you had any injuries related to work? ☐ YES ☐ NO If yes list body part and date.: ____________________

Have you had any Auto Accidents ☐ YES ☐ NO If yes list body part and date.: ____________________

Have you had Physical Therapy or Massage Therapy before? ☐ YES ☐ NO Where:

Signature of Patient, Parent, Guardian, Personal Representative ____________________ Date ____________

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Patient Authorization

Patient Name:_______________________________________ Date of Birth:______________ Age_____

Release of Information & Consent for Treatment

All information provided herein is true and correct.

I am aware of my diagnosis and wish to receive treatment at Arizona Multisports Physical Therapy. I permit its employees and all other persons caring for me to treat me in ways they judge beneficial to me. I understand that this care can include evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to Arizona Multisports Physical Therapy to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it related to my treatment or payment for services provided.

I authorize Arizona Multisports Physical Therapy to obtain medical records and/or professional information from my physicians or other medical professional as it related to my treatment.

The signature below certifies that I have read and understand the above information. Initial:____________

Assignment of Benefits

I authorize payment directly to Arizona Multisports Physical Therapy and/or its affiliates for services and to bill and release payment to Arizona Multisports Physical Therapy and/or its affiliates.

This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

Initial ____________

Notice of Privacy Practices (HIPPA Acknowledgement/Consent)

I hereby acknowledge that I have reviewed a copy of The Notice of Privacy Practices for Arizona Multisports Physical Therapy, its subsidiaries, and/or affiliates.

In addition, I hereby consent to the use and disclosures of my personal health information for the purposed of treatment, payment, and health care operations.

Initial ____________

Phone: 623-266-7866 • Fax: 623-266-7855 • 7055 W. Bell Rd., Ste #1 • Glendale, AZ 85308 • therapy@AZmultisportsPT.com

Payment Guide

I agree to pay Arizona Multisports Physical Therapy for the services provided to me or the party named above. If any law, such as workers' compensation, or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

The benefit Verification is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment of services.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of Arizona Multisports Physical Therapy.

Initial ______________

Patient or Guardian Signature:____ Date:____________________

Welcome to Arizona Multisports Physical Therapy

We are pleased to have you as a new patient to our facility. Below is a list of helpful tips to make physical therapy work to your advantage:

NO SHOW/CANCELLATION POLICY:

_______ As a courtesy, we ask that you call no less than 24 hrs in advance. We reserve the right to charge a $25.00 No Show/Cancellation fee, which includes appointments not cancelled within a 24 hr period

BENEFITS AND PAYMENTS:

________ As a courtesy to you, we will verify your insurance benefits. However, this is a quote from your insurance company, not a guarantee of benefits. Please be advised that any changes in your benefits will be your responsibility. All co-pays, deductibles, and coinsurances are due at the time of service. We accept cash, check, Visa and MasterCard.

ATTIRE:

_______ Loose fitting or athletic attire is suggested. A changing area is available for you to use.

We are committed to providing you with top quality care. The outcome of our therapy is mostly based on a partnership between you and your therapist. Please feel free to ask our staff if you have any questions.

I have read and understand the policies and will comply with the recommendations. I have also received a copy of this letter for my records.

_______________________________________ _______________________________________

Patient Signature Date

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Patient Information

SS#:_______-______-_________ Patient's Name: ____

Permanent Address: ____ Apt# ______

City:____ State: ____________________ Zip:___________________

Local Address:____Apt#______

City:_______________________________________ State:_____________________ Zip:___________________

Date of Birth:______/_______/________ Age _____ Sex: (M / F) Marital Status: (S / M / W / D)

Phone# (_____)_______-___________ Work Phone# (_____) ______-_________________

Cell Phone# (_____)_______-___________ Email Address____

Primary Care Physician: _________________________________ PCP Phone (_____)_____ - __________

Patient Employer: ______________________________________ Position: ________________________________

Employer Address ____

Insurance Information

PRIMARY Company Name ____ Phone #______________________

Address ____

Policy # ______________________________________ Group #_________________________________

Subscriber __________________________ Relationship to patient _______________________________

SECONDARY Company Name _______________________________________ Phone #______________________

Address ____

Policy # ______________________________________ Group #_________________________________

Subscriber __________________________ Relationship to patient _______________________________

Who may receive your Protected Health Information?

Spouse/Parent/Friend/Significant Other:____

Date of Birth _____/______/_______ Age _______ Phone #____________________________________

May we leave messages regarding test results and appointments on your answering machine? Y____ N______

1. I authorize the release of any medical information necessary to process this claim as well as to my physician(s).

2. I request payment of Government Benefits either to myself or to the party who accepts assignments.

3. I also authorize payment of medical benefits to be paid to Arizona Multisports Physical Therapy for services. I understand that I am financially responsible for any balance.

4. I consent to the treatment and/or examination under the supervision of my attending Therapist.

5. I have received Arizona Multisports Physical Therapy's Notice of Privacy Practices and authorized the above list of persons who may receive my Protected Health Information. I may revoke this at any time by giving written notification to this provider.

IF YOU HAVE TWO INSURANCE COMPANIES, PLEASE PRESENT BOTH CARDS SO THAT WE MAY FILE WITH YOUR SECONDARY CARRIER FOR ANY BENEFITS DUE YOU.

____ _________________________________

PATIENT/GUARDIAN SIGNATURE DATE

Verification for Office Use

Date________ Talked To____________________ Phone #____________________ Coverage renewal __________

Visit Limit Per Yr ________ Insurance Pays ____________ Deductible/Yr____________ Amount Met ___________

Copay/Visit________ Annual Out-of-Pocket Met: Y/N Amt Met ______________ Auth #____________________

Verified by______________________________

NOTICE OF PRIVACY POLICY FOR PROTECTED HEALTH INFORMATION (PHI)

The office of ARIZONA MULTISPORTS PHYSICIAL THERAPY LLC is dedicated to protect your "nonpublic personal health information". This notice is to tell you how and why we collect that information, and who has access to that information.

HOW WE COLLECT YOUR INFORMATION:

Your personal demographic information such as name, address, birth date, social security number, and medical insurance information is obtained from you. This is why we ask you to fill out the patient information sheet and why we ask for a copy of your insurance card. This ensures that the information we collect is correct.

If you came to our practice through a hospital encounter, we may obtain that information from the hospital. However, on your first visit to this office, we will ask you to fill out our information sheet to ensure that the information we received from the hospital was correct.

We may also ask a doctor or other health care provider who referred you to this practice to give us health information that will enable us to better treat your medical condition. This benefits you in that we will have test results that have already been obtained by the referring entity.

WHY WE COLLECT THIS INFORMATION:

We collect this information so that we can treat your medical condition and obtain payment from you or your health insurance.

MAINTAINING ACCURATE AND TIMELY INFORMATION:

To ensure that the information we maintain is accurate, each time you visit this office you will be asked if any of your information needs to be updated.

WHO HAS ACCESS TO THIS INFORMATION:

Any person or persons you designate in writing, people directly involved in your medical care, people creating and maintaining your medical record, and those entities that need your information to process health care claims and obtain payment for our services have access to your Protected Health Information.

Entities such as Governmental Oversight agencies, Judicial and Administrative Proceedings, Law Enforcement Agencies, Coroners and Medical Examiners, and Organ Procurement Organizations may obtain copies of your Protected Health Information. These entities are mandated by Law and this practice has no jurisdiction over such entities.

HOW WE PROTECT YOUR INFORMATION:
We release your information only to those people who need your information. We maintain physical, electronic, and procedural safeguards so that no one but persons involved in your healthcare or entities who need this information for claims processing have access to your Protected Healthcare Information.

YOUR RIGHTS:
You have the right to inspect your Protected Healthcare Information. You also have the right to amend any errors you may find in your record.

If you leave this practice, your Protected Healthcare Information will continue to receive the protection outlined in this notice.

COMPLAINT/COMMENTS:
If you have any complaints concerning our privacy practices, you may contact the Secretary of the Department of Health and Human Services, at 200 Independence Avenue, S. W. Room 509F, HHH Building, Washington D.C. 20201. You also may contact the Privacy Officer of this practice at (623)266-7866.

THIS PRACTICE reserves the right to amend our privacy policy as dictated by law, without sending you a copy of the amendment. Any changes to this policy will be posted in our office.

This notice is effective as of September 1, 2009.