A+ Physical Therapy

3180 S Gilbert Rd., #5, Chandler, AZ, 85249
Office (480) 773-7778 Fax (480) 773-7851

PATIENT INFORMATION

Last Name:_____ First Name:_____ MI:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell:_____

Date of Birth:_____ Gender: Male Female Patient Social Security:_____

E-mail _____

A+ Physical Therapy sends out an e-mail appointment reminder? Yes No

Marital Status: Married Single Divorced Separated Widowed

Emergency Contact:_____ Relationship:_____ Phone:_____

Primary Care Physician:_____ Phone:_____

Referring Physician:_____ Phone:_____

How did you hear about our office? Ex. Google, Yahoo, friend, yellow pages, etc, _____

Responsible Party/Insured Party Information (Please fill out completely if other than Self)

Responsible Party: Self Last Name:_____ First Name:_____

Date of Birth:_____ Social Security #:_____ Relationship:_____

Address:_____

Responsible/Insured Party's Employer:_____

Patient Employment Information

Employment Status: (Circle One) Full Time Part Time Not Employed Retired Student

Patient's Employer/School:_____

Patient Name:_____ Height:_____ Weight:_____

Today's ailment (brief description of onset):_____

_____

Affected side: Left Right

Date of injury or onset of problem:_____ Dominant hand: Left Right

What is your occupation?_____

Work related? Yes No Auto Accident? Yes No Attorney involved? Yes No

Have you had x-rays taken? Yes No If yes, where?_____

Have you had a MRI? Yes No If yes, where?_____

Drug Allergies: Yes No Please list drug and reaction:_____

Daily Medications: (please include pain meds, herbs, vitamins & OTC)

_____

Past Surgical History: (List type and date)

_____

Do you exercise? Examples: running, bike riding, cardiovascular, etc.

Yes No How often?_____ What type?_____

Do you smoke? Yes No How often?_____ Packs per day?_____ For how many years?_____

Do you drink alcohol? Yes No If yes, average consumption per week?_____

Are you now or could you possibly be pregnant? Yes No

Has any blood relative younger than 50 ever had unusual bleeding tendencies? Yes No

If yes, who and what is their age:_____

Do you now or have you ever had:

ANEMIA	YES	NO	ASTHMA	YES	NO	BLOOD CLOTS	YES	NO
DIABETES	YES	NO	NEUROLOGICAL DISORDER	YES	NO	AIDS/HIV	YES	NO
CANCER/TYPE.....	YES	NO	DEPRESSION	YES	NO	SUBSTANCE ABUSE	YES	NO
KIDNEY	YES	NO	STROKE	YES	NO	BLADDER TROUBLE	YES	NO
HIGH BLOOD PRESSURE	YES	NO	THYROID DISORDER	YES	NO	ARTHRITIS/GOUT	YES	NO
HEART TROUBLE	YES	NO	STOMACH PROBLEMS	YES	NO	ULCER	YES	NO
BLEEDING DISORDER	YES	NO	HEPATITIS	YES	NO	SEIZURES	YES	NO

PATIENT INFORMATION continued…

MESSAGES: May our office leave messages on your voice mail or answering machine regarding your healthcare, including but not limited to appointments, or other necessary treatment information at the stated numbers on this form. YES_____ NO_____

May our office leave messages with family members, friends, or other individuals that answer at the listed numbers on this form? YES____ NO_____

Authorization to Release Information: I hereby authorize A+ PHYSICAL THERAPY INC. to release information required in the course of my examination or treatment to the stated insurance companies.

Signed (Patient or Parent, if minor):_____ Date:_____

Authorization to Pay: I understand it is my responsibility to know my insurance policy and I also understand I am financially responsible for the charges not covered by my insurances such as my deductable and co-insurance. In the event of default, I promise to pay collection cost and reasonable fees as may be required to obtain collection of this account.

Signed (Patient or Parent, if minor):_____ Date:_____

In order to control the cost of billing, A+ Physical Therapy Inc. requests payment of all co-pays at the time of service.

_____ (Initial if applicable) If you are SELF-PAY, Please pay the balance in full at the time of service. In the event you are unable to pay the balance in full, please advise us prior to the time of service. Please be advised we are not a credit grantor, and therefore, failure to maintain these arrangements may result in the placement of you account with an agency or attorney for collections.

Cancellation Policy: All cancellations must be received 24 hours prior to your appointment or a $20.00 charge will be added to your bill. **The charge for no-shows is $40.00**

Signed (Patient or Parent, if minor):_____ Date:_____

CONSENT TO TREAT:

The undersigned hereby consents to any therapy, treatment, or facility services rendered to the patient under the general and special instructions of the therapist assigned to care for me. I also acknowledge that no guarantee or warranty has been made by said therapist of A + Physical Therapy as to the results of any treatment given or performed.

Patient:_____ Date:_____

Parent/ Guardian:_____ Date:_____

Summary of Privacy Practice

As of April 14, 2003 new federal laws mandated in the Health Insurance Portability and Accountability Act of 1996 (HIPPA). HIPPA is concerning patient privacy and access to medical records. The purpose of this is to outline how these new laws affect you as a patient of A + Physical Therapy.

Patient's Rights to Access Records

- **You have the right to request your records or to request a copy of your records**. Upon receipt of your written request our office will contact you to make arrangements to review your records in the A Plus P.T. office or to copy the records you have requested

- **You have the right to request a written summary or explanation of your records** Upon receipt of your written request, our Privacy Officer will arrange for your P.T. to review and summarize your records.

- **You have the right to request a limited accounting of disclosures of your records.** You may request an accounting of any disclosures of your health info to purposes other than treatment, payment, or healthcare administration.

Rights to privacy

- **You may request additional protections for sensitive health information or to limit disclosures of portions of your health information.** In addition to the protection for Highly Confidential Information specified by HIPAA, you may request in writing that other sensitive info be protected. Our office will take steps to implement these protections and to inform you of the limits of these steps.

- **You may designate a personal health care representative.** You may designate someone to act as your personal health representative. This person would have the same rights of access as you, for your healthcare information. You may change your designated person at any time.

- **You have a right to request that your personal health information be communicated to you in a different manner or at a different location.** You must make this request in writing

Rights of Parents of Minor Children

As the parent or guardian of a minor child, you have the same rights of access to your child's records as to your own, with the following exceptions:

- Your rights to access of the minor child's medical records have been revoked or limited by a court of law

- Your minor child is an emancipated minor under the law.

- Services are provided to your child under the regulations of the state of Arizona.

Your Responsibility under HIPAA

In order to safeguard your rights under HIPAA you have a responsibility to keep A+ Physical Therapy informed of any changes that would affect the disclosure of your personal health info. You have an obligation to:

- Provide accurate information about your address, telephone number, and insurance coverage each time you visit.

- Report any changes in your personal health representative, emergency contact information, and structure of your family.

- Respect the privacy rights of other patients.

A+ Physical Therapy

- Our first responsibility as always is to safeguard the health of our patients. If a provider believes any of the provisions of HIPAA could endanger your life of physical safety or that of another individual the practice must act in accordance with this belief and do what is in the best interest of the patient.

- We are also responsible for safeguarding your privacy. We have an obligation to keep you informed of any disclosures of your personal health info. Outside of those required for treatment, payment of services, and healthcare administration.

- We also have an obligation to work with you to ensure your rights under HIPAA. Our privacy officer with the support of all of the physical therapist and staff will work directly with you to ensure your rights to privacy and to access under HIPAA.

- Any patient believing his or her privacy rights have been violated may file a complaint with the privacy officer at A+ PT

- A+ Physical Therapy reserves the right to change the terms of this notice and make the new terms apply to all protected health information it maintains

Our privacy officer can be reached at **480-773-7778**

_____ _____

Signature of Patient or Representative **Date**