Welcome to Above & Beyond Physical Therapy

Today's Date _____

Last Name _____ **First** _____ **MI** _____ **□Male□Female**

Date of Birth _____**SS#** _____ **□Married □Single □Divorced □Widow**

Race _____ **←Leave Blank to Decline→ Ethnicity** _____
White Am Indian/ Alaska Native Asian Black/African American Hawaiian/Pacific Islander Other Hispanic/ Latino Not Hispanic/ Latino

Street Address _____

City _____ **State** _____ **Zip** _____

Home phone _____**Cell phone** _____

Work phone _____**Email Address**_____

Best way to contact □Phone □Email □ Both May we leave messages □Yes □No
If no please explain_____

Employer /School_____
□Full Time □Part Time □Retired □Student Full Time □Student Part Time

Emergency Contact: Name _____ **Phone** _____

Relationship: _____

Were you involved in a motor vehicle accident □Yes □No

Primary Insurance

ID #	**Group #**
Insurance Company	**Insured's Name (if not self)**
Insured's DOB	**Relationship**

Secondary Insurance

ID #	**Group #**
Insurance Company	**Insured's Name (if not self)**
Insured's DOB	**Relationship**

Responsible Party Information (if patient is a minor or has a legal guardian)

First Name_____**Last Name**_____

Address_____

SS#_____**Sex**_____**Date of birth**_____

Relationship_____ **Phone Number**_____

Above & Beyond Physical Therapy

Consent to Treatment

I understand that I have been referred for Physical Therapy treatment at Above & Beyond Therapy Services. Above & Beyond Therapy Services will describe for me my individual treatment plan. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to this treatment plan that has been prescribed by my physician and/or recommended by my therapist. By signing this agreement, I consent to have Above & Beyond Therapy Services provide treatment and care as prescribed by my physician and/or recommended by my therapist. **Patient Initials** _____

Patient Authorization for Use and Disclosure of Protected Health Information

By Signing, I authorize Above & Beyond Therapy Services to use and/or disclose certain protected health information (PHI) about me to/from_____. This authorization permits Above & Beyond Therapy Services to use and/or disclose the following individually identifiable health information about me, such as evaluations, progress notes, daily notes MRI reports, X-Ray reports operative reports, protocols, and insurance correspondence. The information will be used or disclosed for the following purpose: "to assist therapist with my treatment." The purpose is provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on the completion of my treatment. I do not have to sign this authorization in order to receive treatment. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed by the recipient and may no longer be protected by the federal HIPAA Privacy Rile. I have the right to revoke this authorization in writing except to the extent the practice has acted in reliance upon this authorization. My written revocation must be submitted to the office manager at: Above & Beyond Therapy Services, 3201 W. Peoria Ave. Bldg D #800, Phoenix, AZ 85029.

Patient/Guardian Signature _____ **Date** _____

Billing Policy/ Acknowledgement of Cancellation Policy/ Assignment of Benefits

As a courtesy we may attempt to obtain verification of benefits from your insurance company at the start of treatment and inform you of the information given to us. Please understand that insurance companies will not guarantee medical benefits over the phone. We can only use this information as an estimated guide. Actual determination is made 4-8 weeks later after we receive notice or payment on the claim from the insurance company. We strongly encourage you to contact your insurance company directly in order to understand your plan's coverage and limitations.

It is your responsibility to make sure we have accurate insurance carrier and billing information. If a claim is denied because of flawed insurance or billing information, including fraudulent attempts to obtain services, you will be responsible for the balance unless attempts to rectify these errors result in successful payment of your claim.

I understand and agree that I am ultimately responsible for any balance whether my insurance pays or not.

Please remember the deductible, co-insurance and co-pays are what your insurance requires we collect from you and is an agreement between you and your insurance company and we **are not** part of that contract. These amounts will be due at time of service. If charges or balances are a burden that would limit your attendance, please ask for the billing department to discuss a payment plan.

Missed or canceled appointments **without 24 hours notice** will be subject to a **$25 fee**. This fee is **not covered by insurance** and is the responsibility of the patient. A $30 service fee will be charges for returned checks. A fee of 34% - 50% will be added to unpaid balances that require collection and/or legal services.

I authorize any benefits payable under my insurance plan for services provided to be paid directly to Above & Beyond Therapy Services.

Patient/Guardian Signature _____ **Date** _____

Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient/Guardian Signature _____ **Date** _____

PRESENT ILLNESS HISTORY

Today's Date _____ **Name** _____
Area of Injury or Pain: _____
Date of Onset (exact date required for work injuries) _____
How did this injury occur? _____
Date of last MD appointment _____ **Date of next MD appointment** _____
What other treatment have you received for this problem? _____
What diagnostic tests have been done for this condition?
☐**X-ray** ☐**CT Scan** ☐**MRI** ☐**Other** _____
What type of work do you do? _____ **Are you on light duty?** ☐**Yes** ☐**No**
Have you lost time from work? ☐**Yes** ☐**No** ☐**Off work now due to injury** ☐**Retired**

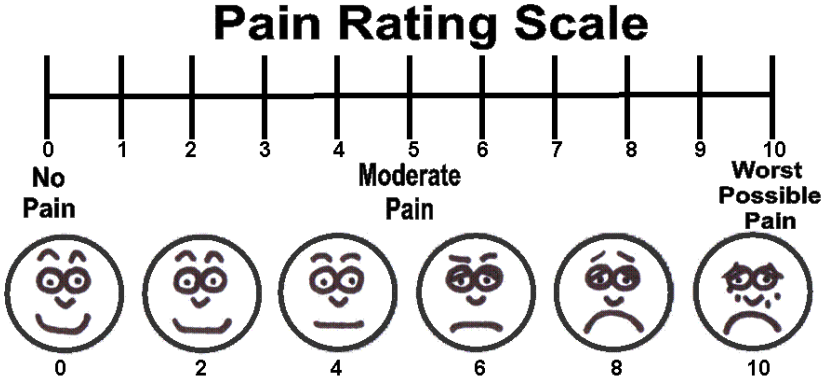
REQUIRED: List 3 specific activities you have difficulty performing:
(Examples are dressing, doing dishes, housework, playing sports, gardening, playing with or lifting your children, specific work duties, sitting or standing for more than 10 minutes, unable to walk more than 20 min.)

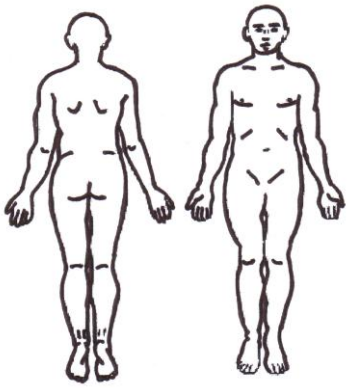
1. _____
2. _____
3. _____

Rate the percentage of function you have LOST due to this injury.

_____**% Loss of function**
(0%= NO loss)

Rate your average pain level on table below (circle one) and mark on the body pain location(s).





XXX Sharp
OOO Dull
+++ Numb
~~~ Ache

List ALL medications you are currently taking: _____
_____
List any allergies you have: _____
List all major surgeries you have had: _____
ANY prior PT for ANY condition in last 3 years: ☐**YES** ☐**NO** **Explain:**

Indicate below if you have had any of the following conditions:

AIDS/HIV	Yes☐ No☐	Fibromyalgia	Yes☐ No☐	Osteoporosis	Yes☐ No☐
Anemia	Yes☐ No☐	Head Injury	Yes☐ No☐	Pacemaker	Yes☐ No☐
Appendicitis	Yes☐ No☐	Heart Condition	Yes☐ No☐	Parkinson's	Yes☐ No☐
Arthritis	Yes☐ No☐	Hepatitis	Yes☐ No☐	Pinched Nerve	Yes☐ No☐
Asthma	Yes☐ No☐	Hernia	Yes☐ No☐	Polio	Yes☐ No☐
Bleeding Dis.	Yes☐ No☐	Herniated Disk	Yes☐ No☐	Prostate Cancer	Yes☐ No☐
Breast Lump	Yes☐ No☐	High Blood Pressure	Yes☐ No☐	Rheumatoid A.	Yes☐ No☐
Bronchitis	Yes☐ No☐	High Cholesterol	Yes☐ No☐	Skin Disorder	Yes☐ No☐
Cancer	Yes☐ No☐	Kidney/Liver Disease	Yes☐ No☐	Steroid Use	Yes☐ No☐
Concussion	Yes☐ No☐	Fractures	Yes☐ No☐	Stroke	Yes☐ No☐
Depression	Yes☐ No☐	Lung Condition	Yes☐ No☐	Tuberculosis	Yes☐ No☐
Diabetes	Yes☐ No☐	Migraines	Yes☐ No☐	Tumors	Yes☐ No☐
Drug Addiction	Yes☐ No☐	Multiple Sclerosis	Yes☐ No☐	Ulcers	Yes☐ No☐
Smoking	Yes☐ No☐	Currently Pregnant	Yes☐ No☐	Joint Replaced	Yes☐ No☐
High Stress	Yes☐ No☐	Reason for stress: _____			
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