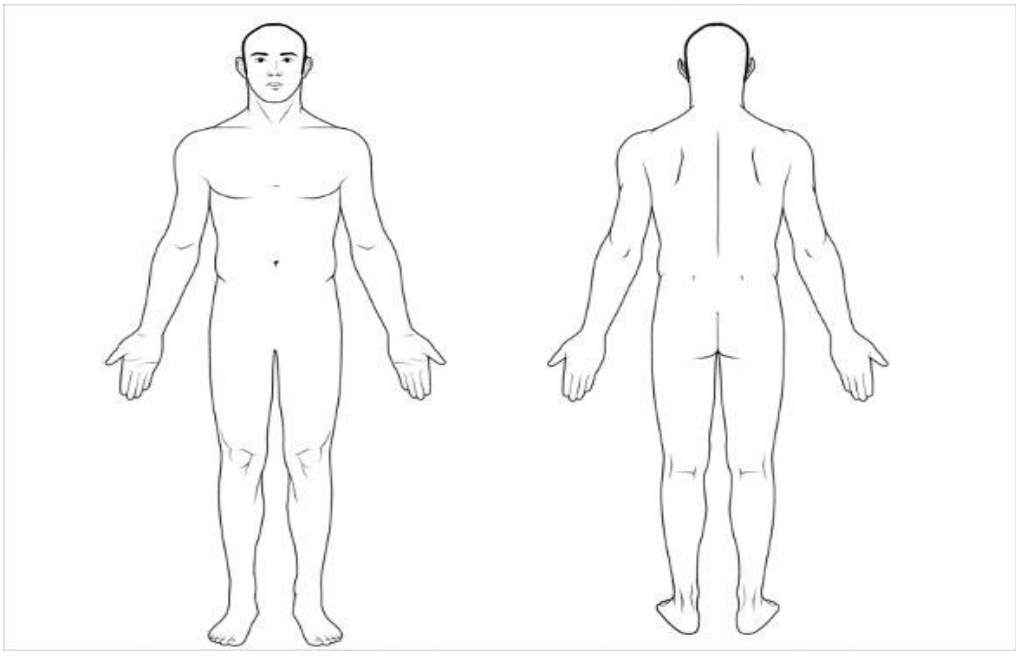
PATIENT QUESTIONNAIRE

DATE: **PATIENT NAME:** **DOB:**

OCCUPATION: **□ FULL-TIME** **□ PART-TIME**

HAVE YOU SEEN A PHYSICAL THERAPIST FOR THIS CONDITION BEFORE? □ YES □ NO **IF YES, WHERE AND WHEN?**
HAVE YOU RECEIVED ANY RECENT TESTS (CT SCAN, EMG, MRI, XRAY, ETC…)? □ YES □ NO **IF YES, WHAT TEST WAS DONE?** **IF YES, WHERE WAS THE TEST ADMINISTERED?**
PLEASE LIST ALL MEDICAL CONDITIONS THAT YOU ARE TREATING FOR (OR HAVE TREATED FOR IN THE PAST) **(HIGH BLOOD PRESSURE, HEART DISEASE, AUTOIMMUNE, ANXIETY, DEPRESSION, ETC…)**
HAVE YOU EVER BEEN DIAGNOSED WITH CANCER? □ YES □ NO **IF YES, WHAT KIND?** **IF YES, WHEN?**
PLEASE LIST ALL CURRENT PRESCRIPTION MEDICATIONS:
PLEASE LIST ALL SURGERIES AND / OR HOSPITALIZATION:
DO YOU SMOKE? □ YES □ NO

PLEASE MARK WHERE YOU ARE HAVING (OR HAVE HAD) SYMPTOMS:



Desert Palms
Physical Therapy
Movement Studio
Institute

PATIENT NAME:_____

PRIVACY PRACTICES

As a patient of Desert Palms Physical Therapy, you have certain rights under Federal Law to the privacy of information we obtain about you. Desert Palms Physical Therapy takes all reasonable measures to safeguard, respect and protect patient confidentiality.

No information regarding your care at Desert Palms Physical Therapy will be disclosed to any party without your written consent. This includes all individually identifiable health information, in any form, transmitted orally or in written or electronic form.

You will be provided access to your medical record for review by providing written notice. You have the right to receive a copy of your medical record by providing written notice. You have the right to request charting errors be corrected. You must authorize disclosure of information for purposes other than treatment, payment and health care operations.

Information regarding your care will only be released to the primary care physician or specialist physicians treating you. Information regarding your care will only be released to the insurance company(ies) you indicate on your enrollment form as responsible for payment of your services. We may disclose your protected health information to the extent required by State or Federal Law.

If your account remains unpaid and we are forced to turn your account to a collection agency, we will provide your billing information to Transworld Systems.

Desert Palms Physical Therapy has designated our Clinical Supervisor as the individual responsible for ensuring our privacy practices are followed. Patient medical records are secured by lock each night. The Desert Palms Physical Therapy building is armed with a monitored security system each night.

AUTHORIZATION TO RELEASE RECORDS / ASSIGNMENT OF BENEFITS
AUTHORIZATION TO DEPOSIT CHECKS

I authorize release of medical records to my primary care physician and my prescribing physician, and to release any medical records to my insurance company necessary for processing insurance claims. I authorize my primary care physician and my prescribing physician to release any medical records to Desert Palms Physical Therapy (DPPT).

I authorize payment of my medical insurance benefits to be made directly to Desert Palms Physical Therapy (DPPT) in accordance with my medical insurance policies. I assign payment of benefits directly to DPPT. **It is my responsibility to contact my insurance company to determine if DPPT is a contracted provider for my insurance coverage. It is my responsibility to inform DPPT of any prior authorization requirements for services. I acknowledge I will be responsible for any balance that my insurance company does not cover for any reason.** I hereby instruct my insurance company to pay DPPT directly for services rendered. We are unable to bill Medicare for treatment as a result of an automobile accident. If policy prohibits payment directly to the provider, I hereby instruct my insurance company to issue the payment check in my name and mail it directly to DPPT. I authorize DPPT to deposit payment checks received on my account when made out in my name. I authorize DPPT to initiate a complaint to the Insurance Commissioner on my behalf for non-payment of my insurance claims.

A photocopy of this assignment shall be considered as valid as the original.

I understand there will be a finance charge of 1.5% per month (18% per annum) on all unpaid balances (deductibles, co-payments, co-insurance). If my account is referred to a collection agency for non-payment by me, I agree to pay all collections fees and reasonable attorney fees and court costs.

FOR PATIENTS WITH LIENS an administrative charge of $88 will be added to your account to cover our expense of filing a Lien with Pima County.

SUPPLY PURCHASE AGREEMENT

I understand this office does not bill insurance for supplies. If a Therapist suggests any supply for my benefit or treatment, I understand the supply must be paid for at the time I take possession of the supply.

I understand that all supplies sold by Desert Palms Physical Therapy come into contact with the body when in use. Therefore, in compliance with the Arizona Department of Health regulations, Desert Palms Physical Therapy is unable to return to inventory stock, any supply that has left the building in the possession of purchaser.

I acknowledge that once I purchase a supply I will be unable to return the supply for a refund regardless of the reason. By signing below I acknowledge my understanding that Desert Palms Physical Therapy has a NO RETURN policy for all supply purchases.

APPOINTMENT CANCELLATION AND NO SHOW POLICY

We strictly enforce a missed appointment charge of $25. We require a 24-hour notice if you are unable to keep your appointment. This charge will not be billed to an insurance company and must be paid on the next appointment date. One Courtesy Cancellation will be allowed per patient. Appointment No Shows will be charged $25. Payment of this fee is required prior to the next scheduled appointment.

PATIENT CONSENT FOR EVALUATION

I hereby consent to physical evaluation by Desert Palms Physical Therapy (DPPT). Evaluation may include any necessary examination, test or procedures ordered to be performed by the DPPT staff. I understand that I may refuse evaluation at any time.

_____ _____

PATIENT / GUARDIAN SIGNATURE **DATE**

PATIENT NAME: _____

CONSENT TO RELEASE INFORMATION

I hereby authorize one, or all of, the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified by Desert Palms Physical Therapy before any of my information is released.

NAME	RELATIONSHIP	PHONE NUMBER
NAME	RELATIONSHIP	PHONE NUMBER
NAME	RELATIONSHIP	PHONE NUMBER

PATIENT / LEGAL GUARDIAN SIGNATURE **DATE**

CONSENT TO TREAT MINOR CHILD

I authorize Desert Palms Physical Therapy to perform physical therapy treatment on the child named below. By signing this consent I acknowledge that I am the parent and/or legal guardian of the child named below.

I consent to treatment as prescribed by the physician of the child and/or as recommended by the physical therapist at Desert Palms Physical Therapy. I acknowledge this consent will be in effect when I accompany the child to treatment as well as when the child arrives for scheduled treatment without me.

I authorize the physical therapist to perform any additional or different treatment which is deemed necessary should, during treatment, a condition be discovered which was not known previously.

I have carefully read and understand this Consent to Treat and by signing below authorize Desert Palms Physical Therapy to administer treatment.

NAME OF MINOR CHILD **CHILD'S DATE OF BIRTH**

SIGNATURE OF PARENT / LEGAL GUARDIAN **DATE**

WITNESS SIGNATURE **DATE**