LV PREMIER PHYSICAL THERAPY
& SPORTS PERFORMANCE

www.lvpremierpt.com

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Welcome!

We are pleased that you have selected Premier Physical Therapy & Sports Performance (PPT) for your rehabilitative care and physical therapy needs. Our goal is to have you pain free and functional again in as short of time as possible, but physical therapy is a process and based upon your diagnosis and current status, this process may take a few days or a few months. Please let us know how we can serve you best since you are the reason why Premier Physical Therapy & Sports Performance was founded. We hope you enjoy your time with us as we dedicate ourselves to helping you reach your full recovery potential.

Please fill out the attached forms legibly, accurately and completely. This information will be held in strict confidence in accordance with HIPAA as amended and is essential to ensure your understanding of our billing procedures, our determination of your physical therapy diagnosis and developing your complete, individualized, functional plan of care. You have access to your records upon request at any time (subject to record retention regulations). We will require five to ten business days notice to comply with your request fully.

Thank you!

The *LV* Premier Physical Therapy Team

Premier Physical Therapy & Sports Performance (PPT)
In Partnership with Fallon Physical Therapy

Patient Information

Please print all information in the spaces provided. Be sure to complete all applicable information.

Last Name ______________________ First Name ______________________ M.I________

Preferred Name ____________ ☐ Male ☐ Female DOB __________ SS# ______________

Status: ☐ Married ☐ Single ☐ Widow(ed) ☐ Divorced ☐ Minor ☐ Other Spouse Name: ______________

Address ______________________ Apt#________ City __________ ST______ Zip__________

Primary Telephone Number ( )______________ Secondary Telephone Number ( ) ______________

Email Address ______________________

How would you like to be reminded of your appointments? ☐ Text ☐ E-Mail ______________ ☐ Phone Call #______________

If patient is a minor, parent or legal guardian Full Name______________________ DOB: __________

How did you hear about/referred to PPT?______________________

Referring Doctor: ______________ Phone ( )______________ Next follow-up?__________

Name and phone # of contact in case of an emergency: ______________________ Relation: __________

Insurance Information

Have you received any therapy/treatments this year, such as chiropractic, physical, occupational, or speech therapy? ☐ YES ☐ NO

Primary Insurance

Insurance Company ______________________

Insurance Phone # ______________ Employer ______________

Claims Address ______________________

Name of Insured ______________ DOB __________ Relationship to Patient __________

Insured ID # ______________ Group Number ______________

Secondary Insurance

Insurance Company ______________________

Insurance Phone # ______________ Employer ______________

Claims Address ______________________

Name of Insured ______________ DOB __________ Relationship to Patient __________

Insured ID # ______________ Group Number ______________

If injury is a Workers Comp case or through a Lien, please complete the following:

Is your injury job related? **YES** **NO** Date of injury __________ Claim # ______________

Insurance Company ______________________ Phone # ______________

Name of Adjuster ______________________ Phone # ______________

Is your injury due to a motor vehicle accident? **YES** **NO** Date of injury __________ Claim # ______________

Is your injury due to a Premises Liability? **YES** **NO** Date of injury __________ Claim # ______________

Is your injury due to an Assault? **YES** **NO** Date of injury __________ Claim # ______________

Is your injury due to a Battery? **YES** **NO** Date of injury __________ Claim # ______________

Insurance Company ______________________ Phone # ______________

Attorney (if applicable) ______________________ Phone # ______________

I hereby authorize payment of medical benefits billed to my insurance to PPT. I hereby accept responsibility for payment for any service(s) provided to me which is not covered by my insurance. I also accept responsibility for fees which exceed payment by my insurance if the Practice does not participate with my insurance. I agree to pay all copayments, coinsurance, and deductibles at the time the service is rendered.

______________________________________ ______________

Signature of patient or legal guardian/representative **Date**

Premier Physical Therapy & Sports Performance (PPT)

Please Read & Initial All…

_____ **Cancellation Policy** We request that when possible you give us 24-hour notice if you need to cancel an appointment. We are flexible and understand that situations beyond our control do arise. We will work with you to get your appointment rescheduled without penalty if you call us prior to your appointment time. By initialing, you acknowledge that it is at our discretion to charge you a fee of $85 if you "no call, no show" an appointment.

_____ **Financial Policy** I understand that I am financially responsible for all charges for services to me, including the balance remaining after payments of possible insurance benefits. I understand that when applicable, my payment portion is collected at the time services are rendered. I hereby authorize payment of medical benefits billed to my insurance to PPT. I hereby accept responsibility for payment for any service(s) provided to me which is not covered by my insurance. I also accept responsibility for fees which exceed payment by my insurance if the Practice does not participate with my insurance. I agree to pay all copayments, coinsurance, and deductibles at the time the service is rendered.

____ **Collection Policy:** I understand that any outstanding balance on my account may be referred to an outside collection agency or attorney; if so, a collection fee of 33% will be added to the total balance due at the time my account(s) are referred. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. By initialing, I have read this disclosure and agree that PPT/collection agency/attorney may contact me as described above.

_____ **Assignment of Benefits** I authorize payment of medical benefits to me or the names provided for professional services rendered by PPT.

_____ **Release of Information** I authorize the release of any medical information necessary to process this claim, in compliance with HIPAA guidelines.

_____ **Privacy Information** As required by law, I acknowledge that I have been provided access to the HIPAA guidelines as amended which are available at the PPT front desk.

_____ **Treatment Consent** I authorize any and all physical therapy required to be performed by Premier Physical Therapy & Sports Performance.

_____ **Minor Children** recognize that any Minors/Children that may accompany me to my appointments will be my responsibility and I accept liability for their actions in and around the facility and I release LVPPT from all responsibility and liability. I agree to comply with the requests of the staff, if my minor's actions become disruptive.

_____ **Contact** You agree in order for PPT/Collection Agency to service your account, collect any amounts you may owe or convey any other information regarding your treatment (including, but not limited to, appointments, insurance information, health care information, surveys, marketing content, and/or balance forwards, etc.), PPT/Collection Agency may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers which could result in charges to you. PPT/Collection Agency may also contact you by text messages or emails using any email address or any telephone number you have provided to us at any time.

____ ______________________

Signature of patient or legal guardian/representative **Date**

Premier Physical Therapy & Sports Performance

Arturo Hernandez, PT, DPT, ATC   Tim Kuhn, DPT, CSCS, CAFS   David Ishii, DPT, ATC, CSCS

Commitment Agreement

All of us at Premier Physical Therapy & Sports Performance are dedicated to providing you with the best possible care and are excited about the opportunity to help you with your recovery. Education and experience enables our therapists to be sensitive to your specific needs and abilities and then adapt our interventions accordingly. Our physical therapy programs employ a balanced blend of manual therapy and functional/corrective therapeutic exercise specially designed to help you reach your specific goals by minimizing your pain and maximizing your recovery potential.

Physical therapy is a process much like taking antibiotics; once you start you need to finish the regimen before stopping the intervention to maximize your benefit and to minimize your chance of re-injury or flare-up. This process can take a few days or even a few months (dependent upon condition) for optimal results to be achieved and it takes dedication by both you and your PPT team to ensure maximum benefit. We have committed ourselves to you and ask that in return you will dedicate yourself to:

- Schedule appointments according to your doctor's prescription or therapist's discretion.
- Be consistent in your attendance by not missing scheduled appointments.
- Be dedicated to your home exercise program and self-treatment so that you can achieve the best possible result.

To assist you in your commitment, we offer lunch hour appointments, extended hours, and a willingness to adjust our schedule times to better serve you and your busy lifestyle. We are here to help you achieve the best possible outcome so please let us know how we can better serve you along the way.

Please sign below to verify your commitment to the process of physical therapy and dedication to your individualized program, as it is the most vital part in achieving the best result.

Name: ____ Date: ____________

Premier Physical Therapy and Sports Performance (PPT)
HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text, as amended, is posted in the office and is available upon request.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information, illustrations and the full complete law, which includes educational videos, are available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, and health insurance payors as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is not the policy of this office to remind patients of their appointments. If, however, we choose to do so, we may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology which you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA and have been offered Business Associate Contracts to execute.

4. You understand and agree to random inspections of the office and review of documents which may include PHI by government agencies or insurance payors in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the HIPAA Compliance Officer or the physical therapist. If you do not believe your complaints are being heard or acted upon you may contact HHS.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in a timely manner in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of both PPT and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, ______________________________, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward even though amendments may be enacted.
DATED: ______________

Premier Physical Therapy and Sports Performance (PPT) Medical History

(Federal regulations require a medical history to be included in your medical chart)

Patients Name: ______________________________________ Date: ___________________

Date of injury/surgery: _________________ Job related? YES NO

Accident related? YES NO

Chief complaint: ____

Do you have/or ever had any of the following:

Diabetes	Yes	No	Sensitive Heat/Ice	Yes	No
High Blood Pressure	Yes	No	Currently Pregnant	Yes	No
Heart Disease	Yes	No	Other Allergies	Yes	No
Heart Attack	Yes	No	Previous Surgery	Yes	No
Pacemaker	Yes	No	Hernia	Yes	No
Headaches (chronic)	Yes	No	Seizures	Yes	No
Kidney Problems	Yes	No	Metal Implants	Yes	No
Nervous Disorders	Yes	No	Cancer	Yes	No
Visual/hearing Impairments	Yes	No	Peripheral Neuropathy	Yes	No
Numbness	Yes	No	Tingling	Yes	No

Other health condition(s) past or present: ____

List Relevant Surgeries: ____

Are you presently taking any medication? Yes________ No_________

Medication Name	Condition
1.________________________	____
2.________________________	____
3.________________________	____
4.________________________	____
5.________________________	____
6.________________________	____

The above information is correct and complete to the best of my knowledge, information and belief

____ ___________________

Patient Signature Date

Rev 7/2015

Patient Health Questionnaire - PHQ

ACN Group, Inc. Form PHQ-202

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name ______________________ ***Date*** ______________________

1. Describe your symptoms ______________________

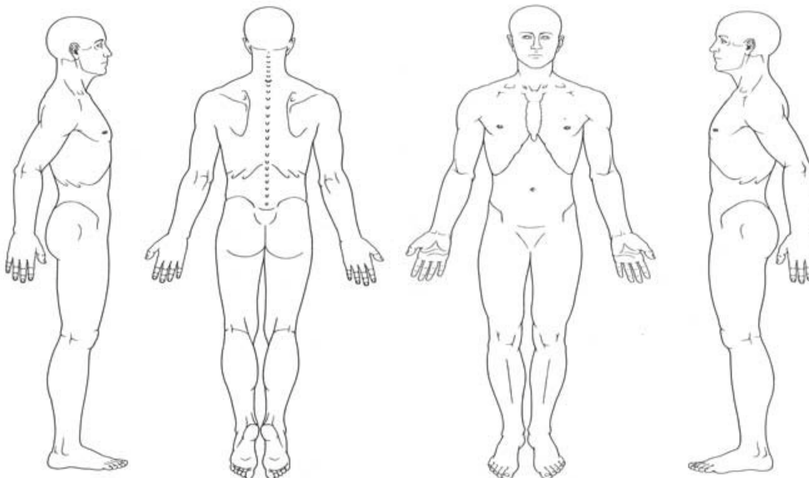
____

a. When did your symptoms start? ______________________

b. How did your symptoms begin? ______________________

2. How often do you experience your symptoms?
- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?
- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

4. How are your symptoms changing?
- ① Getting Better
- ② Not Changing
- ③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ *Unbearable*

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No One ② Other Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other

a. What treatment did you receive and when? ______________________

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* __________ ③ CT Scan *date:* __________

② MRI *date:* __________ ④ Other *date:* __________

9. Have you had similar symptoms in the past?

① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office ② Other Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other

10. What is your occupation?

① Professional/Executive ② White Collar/Secretarial ③ Tradesperson ④ Laborer ⑤ Homemaker ⑥ FT Student ⑦ Retired ⑧ Other

____

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time ② Part-time ③ Self-employed ④ Unemployed ⑤ Off work ⑥ Other

Patient Signature ______________________ ***Date*** ______________________