New Patient Information Sheet

Last Name ______________________________ **First Name**__________________________M.I.______________

Address:__________________________________City___________________State______ Zip_________________

Home#: __________________________**Cell#:**_______________________ **Email:**_________________________

Date of Birth: __________________________ Gender: Male Female **SSN:**____________________________

Martial Status (Circle One): Married Single Divorce Separated Widowed

Emergency Contact: _________________________Relationship: ______________ Phone:_________________

Primary Care Physician: ____ Phone: _________________________

Referring Physician: ____**Phone:** _________________________

Insured Party Information (Please complete if other than self)

Last Name:__________________ First:_____________________ M.I.__________ DOB: ____________________

Address: ______________________________ City: _________________ State:_______ Zip:________________

Home#:_______________________________________ Cell#:____

Insured Party's Employer:____

Is this related to an accident? YES NO Work Auto Other: ______________________________

Do you have an Attorney? YES NO

Insurance Carrier: ____________________________________ Claim # _________________________________

D.O.I. ____

Adjustor/Nurse Case Manager : __________________________________ Phone: __________________________

Insurance Information: (We will also need a copy of your insurance cards)

Primary Insurance: ___________________________ **Secondary Insurance:** ___________________________

Policy Holder:________________________________ **Policy Holder:** __________________________________

DOB:_______________________________________ **DOB:**____

Policy ID#: __________________________________ **Policy ID #:**____________________________________

Group #: ____________________________________ **Group#:** _______________________________________

Assignment of Benefits: I herby assign and authorize payments directly to AZ SportsCenter Physical Therapy & Conditioning Inc. of any benefits or series of benefits due because of liability of a third party, or proceeds of such claims resulting from the liability of a third party organization. I further agree that this assignment will not be withdrawn or voided at any time until all accounts are paid in full. I am not responsible for charges billed above contracted fee schedule for which this facility is contracted. I understand I am financially responsible for all charges not covered by my insurance secondary to waivers or termination of my policy.

Signed: (Patient or Parent, if minor)_______________________________________ Date ___________________

Release or Medical Information: I authorize AZ SportsCenter Physical Therapy and Conditioning Inc. or any professional rendering care of treatment to release medical and supporting documentation of same as complied in the medical records for purposes of benefit payment.

Medical Patient Certification: I certify that this information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of authorized benefits be made on my behalf.

Disclosure of Health Information: I understand that as part of my health care, AZ SportsCenter Physical Therapy & Conditioning Inc. originates and maintains paper or electronic records describing my health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future care of treatment.

I understand that a copy of Notice of Private Practices is available upon request which provides a more comprehensive description of information use and disclosures. I understand my rights and privileges and that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent this organization may refuse to treat me as permitted by Section 164.520 of the Code of Federal Regulations.

I understand that as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure of these permitted uses including disclosures via fax.

I fully understand and accept the terms of this consent.

____ ____

Patient Signature Date

May our office leave messages on your voicemail or answering machine regarding your healthcare, including by 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 this listed numbers on this form? **Yes** ___________ **No**___________

How did you hear about us? ____

....
For Office Use Only: ( ) Consent received by_______________________________________ on____________________________

( ) Consent refused by patient and treatment refused as permitted

( ) Consent added to the patient's medical record on _____________________________

MEDICAL HISTORY

Diagnosis as stated to you by your physician: ______________________

How/ When did this injury/exacerbation occur? ______________________

Have you been hospitalized for the present condition? ☐ Yes ☐ No

Have you had surgery for the present condition? ☐ Yes ☐ No

Have you received previous treatment for this condition? ☐ Yes ☐ No

If yes, please summarize: ______________________

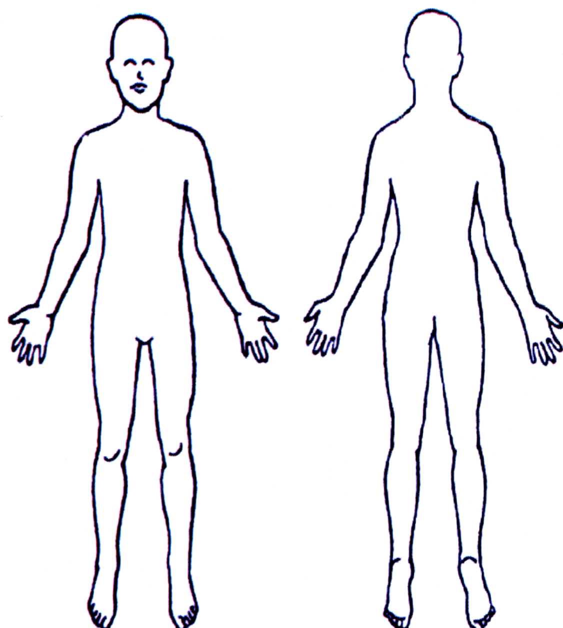
Are you currently taking any medications? ☐ Yes ☐ No

Please list: ______________________

Have you ever had any of the following: ☐ EMG ☐ CT ☐ MRI ☐ XRAY

Have you ever, or are you presently being treated for any of the following conditions?

Diabetes	Yes	No		Bleeding Disorder	Yes	No
Headaches	Yes	No		Fracture	Yes	No
Dizzy Spells	Yes	No		Cancer	Yes	No
Fainting Spells	Yes	No		Pacemaker	Yes	No
Epilepsy	Yes	No		Joint Replacement	Yes	No
Stroke	Yes	No		Respiratory Problems	Yes	No
Pregnancy	Yes	No		Hepatitis	Yes	No
Seizures	Yes	No		Heart Trouble	Yes	No
Osteoporosis	Yes	No		Allergies	Yes	No
Polio	Yes	No		Back Injury	Yes	No
Drug Allergies (please list):				Arthritis	Yes	No
				Others:		
				Others:		



Please rate your current pain level:

0 1 2 3 4 5 6 7 8 9 10

no pain ... worst imaginable

My pain is worse (circle all that apply):

in the morning/ during the day/ at night

constant/ with activity/ during rest

Please mark on the body diagram where you are currently having pain/ symptoms

____

Patient Signature Date

CONSENT TO TREAT:

I, ______________________________, have been advised of the course of treatment as described by my therapist. I have also been advised that any and all changes to my program will be discussed with me.

I have read the above statement and had questions answered and do hereby give my consent to be treated by AZ SPORTSCENTER: PHYSICAL THERAPY & CONDITIONING, INC.

Patient:_________________________________ Date:_____________

Parent/ Guardian: _______________________ Date:_____________

Summary of Privacy Practices

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

Patient's Rights to Access Records

- You have a right to request to see your records or to request a copy of your records. Upon receipt of your written request, our Privacy Officer will contact you to make arrangements to review your records in the AZ SPORTSCENTER office or to copy the records you have requested.
- You have a right to request a written summary or explanation of your records. Upon receipt of your written request, our Privacy Officer will arrange for your physician to review and summarize your records.
- You have a right to inspect and to request an amendment to your records. If, in reviewing your records, you find an inaccuracy in the facts documented or an omission, you have the right to submit an amendment to your record.
- You have a right to request a limited accounting of disclosures of your records. You may request an accounting of any disclosures of your health information 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 protections for Highly Confidential Information specified by HIPAA, you may request, in writing, that other sensitive information be protected. Our Privacy 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 personal representative 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 Responsibilities Under HIPAA

In order to safeguard your rights under HIPAA, you have a responsibility to keep AZ SPORTSCENTER informed of any changes that would affect the disclosure of your personal health information. 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. Etc.
- Respect the privacy rights of other patients.

AZ SPORTSCENTER Physical Therapy & Conditioning, INC Responsibilities

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 or 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 information 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 therapists 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 AZ SPORTSCENTER Physical Therapy & Conditioning, INC or with the Secretary of Health and Human Services.

A complete copy of our privacy policy can be obtained at the receptions area. AZ SPORTSCENTER Physical Therapy & Conditioning, INC reserves the right to change the terms of this notice and to make the new terms apply to all protected health information it maintains.

Our Privacy Officer can be reached at: 480-361-1127

______________________________ ____________________

Signature of Patient Date

If the patient is an unemancipated minor or otherwise incapacitated (physically or mentally), obtain the following signatures:

______________________________ ____________________ ____________

Signature of Personal Representative Description of Authority Date