**Today's Date:** _____ **Last Name**: _____ **First Name**: _____

**Date of Birth:** _____ **SS#**: _____ **Gender**: _____

**Street Address:** _____ **Suite/Apt #**: _____ **City**: _____

**State:** _____ **Zip**: _____

**Home Phone:** _____ **Mobile Phone:** _____

**Email (for appt reminders & newsletter)**: _____

**How did you hear about us?** ☐ **Friend/Family:** _____ ☐ **Google** ☐ **Yelp**

☐ **Event:** _____ ☐ **Newspaper:** _____ ☐ **Other:** _____

**Referring Physician:** _____

**Insurance(s):** _____ **Policy Holder:** _____

**Policy Holder DOB:** _____ **Relationship to Policy Holder:** _____

**Emergency Contact** **Name:** _____ **Phone:** _____

**Relationship:** _____

**Patient Information Acknowledgement:**

I have read and fully understand Foundational Physical Therapy, LLC (Chandler Physical Therapy) notice of patient information practices. I understand that Foundational Physical Therapy, LLC (Chandler Physical Therapy) may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payments, evaluating the quality of service provided, and for any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that Foundational Physical Therapy, LLC (Chandler Physical Therapy) will consider request for restrictions on a case by case basis, but does not have to agree to requests of restrictions. I hereby consent to the use and disclosure of my personal health information for purposes as noted in Foundational Physical Therapy, LLC (Chandler Physical Therapy) notice of patient information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at this time.

**PATIENT INITIAL:**

**Consent to Treatment:**

I understand I have the right to ask any questions in regards to my individual treatment plan prior to receiving any treatment. By signing this agreement, I hereby give consent to receive treatment from Foundational Physical Therapy, LLC (Chandler Physical Therapy) as prescribed by my physician and/or recommendation by my therapist.

**PATIENT INITIAL:**

## Appointment Cancellation Policy:

All patients are required to provide a **24 hour notice** to Foundational Physical Therapy, LLC (Chandler Physical Therapy) if you are unable to attend a scheduled appointment. There will be a **$25 fee** for any no show or cancellation made less than 24 hours before your scheduled visit.

**PATIENT INITIAL:**

CHANDLER PHYSICAL THERAPY

**Patient Name:** _____

**Briefly describe the history of your condition:** _____

**When did this start?** _____

**Have you receive any other treatments for your current condition?** _____

**Have you received the following:** ☐ **MRI** ☐ **X-ray** ☐ **CT scan** ☐ **Other:** _____

**Please list (or supply a copy) your medications that your are currently taking:** _____

_____

**List all major surgeries:** _____

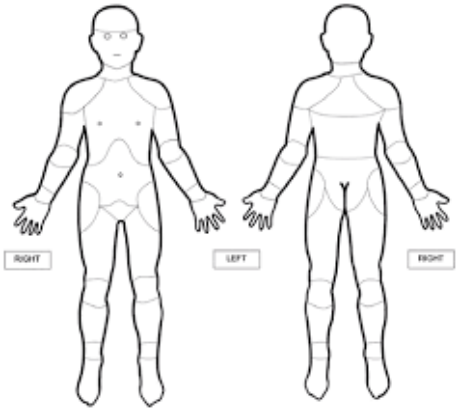
**Have you ever had physical therapy before?** ☐ **NO** ☐ **YES** **When:** _____

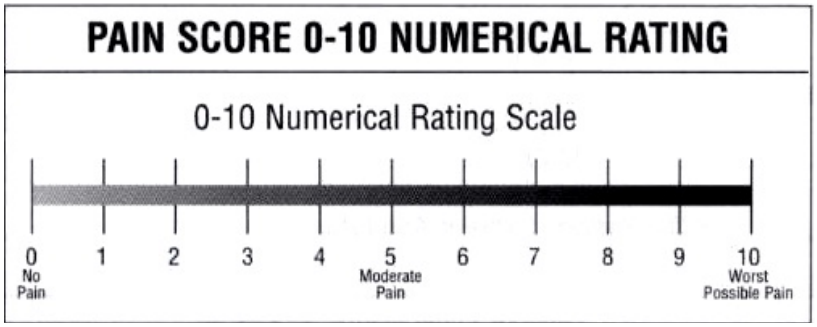
**What do you do for work?** _____

**List all activities you have difficulty performing:** _____

_____

**On a scale from 0-10 (where 10 is having to go to the hospital) how severe is your pain? Where is your pain located?**




**Are your symptoms:** ☐ **Getting better** ☐ **Staying the same** ☐ **Getting worse**

**How are you able to sleep at night?** ☐ **Good** ☐ **Moderate difficulty** ☐ **Poor**

**Indicate if you have had a history of any of the following conditions:**

| | | | | |
|---|---|---|---|---|
| Diabetes | Osteoarthritis | Liver/Kidney disease | Fibromyalgia | Head injury |
| High Blood Pressure | Rheumatoid arthritis | Lung condition | Circulatory problems | Hepatitis |
| Heart Condition | High cholesterol | AIDS/HIV | Currently pregnant | Herniated disk |
| Stroke | Smoking | Seizures | Dizziness/fainting | Pinched nerve |
| Osteoporosis/penia | Chest pain | Hernia | Polio | Joint replaced |
| Pacemaker | Shortness of breath | Blood thinners | Parkinson's | |
| Cancer | Allergies | Bleeding disorders | Multiple sclerosis | |
| Depression | Asthma | Fractures | Numbness/tingling | |

# HIPAA/Privacy

## Uses and Disclosures of Protected Health Information

Purpose: to ensure that disclosure of Protected Health Information (PHI) is made consistent with applicable laws, regulations and health information standards, and to ensure that any disclosures of a patient's PHI to a patient's family members, other relatives, close friends, or other persons designated by the patient are appropriate.

Policy: Disclosure of PHI will only be allowed with a properly completed and signed authorization except:

- when required or allowed by law:
  - for continuing care (treatment)
  - to obtain payment for services
  - for the day to day operations of the facility and the care given to the patients

Disclosure of Protected Health Information will be carried out in accordance with all applicable legal requirements. This facility will be responsible for researching and abiding by applicable state laws and regulations.

Original Medical Records **will not** be removed from the premises, except when ordered by subpoena or by other court order.

Request for Medical Records: shall be managed by the Front Office & Billing Department

- Other staff members **will not** release this information without their approval

Information **will not** be released to any other party without the written consent/signature of the patient.

**Patient Signature**: _____

**Patient Name:** _____

**Cash Accounts**: Payment is due **at the time** of service.

**Private & Group Insurance Plans:** You are required to pay your co-pay/co-insurance **at the time** of service.

The support staff of Foundational Physical Therapy, LLC (Chandler Physical Therapy) will bill your insurance company once you have provided a completed insurance information sheet and a copy of your insurance card/cards. This service is provided as a courtesy to you; you are ultimately responsible for **prompt and full payment** for all services provided. We accept cash, checks, MasterCard, or Visa. Please be advised that there will be a $25 service charge added to your account for return checks.

Your insurance is a contract between you, your employer if applicable, and the insurance company. **It is the responsibility of the patient to know their benefits and if prior authorization is required by their insurance company prior to physical therapy treatments. Failure to obtain prior authorization may affect the benefits paid by your insurance company. It is your responsibility to pay for all services regardless of any agreement you may have with an insurance company, employer, union, government, or legal suit.**

**If your insurance company fails to pay the claim in a timely manner, you are responsible for the payment of the contracted amount in full.**

**Medicare**: We at Foundational Physical Therapy, LLC (Chandler Physical Therapy) are authorized by Medicare to provide physical therapy services. We will submit a completed claim electronically to Medicare for you.

**All Patients**: Should your account be referred for collections, the undersigned shall pay reasonable collections expenses including attorney's fees.

## PLEASE READ AND SIGN THE FOLLOWING:

***I authorized Foundational Physical Therapy, LLC (Chandler Physical Therapy) to furnish my insurance company and my physician with all information requested concerning my illness or injury.***

***I authorize and assign any and all money payable to me under the terms of any insurance policy, contract, or third party entitlement as a result of the services provided by Foundational Physical Therapy, LLC (Chandler Physical Therapy).***

***I understand that I am financially responsible for all charges not covered by my insurance.***

| | |
|---|---|
| **PATIENT SIGNATURE:** _____ | **DATE:** _____ |

# Patient-Therapist Communication

Chandler Physical Therapy will be using Google Voice to effectively communicate between you,  the patient, and the Chandler PT Staff while out of the clinic. For example, if you do not have an appointment for the week and/or have any questions, you can quickly send over a text or email to the staff. This method of communication can also be used to confirm/cancel appointments.

**Name:** _____

**Patient preferred method of communication:**

☐ Text (look for a text from 480-630-5045):
_____

☐ Email (chandlerpttech@gmail.com)
_____