Pritchette Physical Therapy
orthopedic & sports rehabilitation
aquatic therapy • sports performance

Patient Registration Information

Please Print

_____ _____-_____-_____

Full Legal Name: First Middle Last Social Security Number

_____ (_____)_____

Address: Street Apartment # Home Phone Number

_____ (_____)_____

City State Zip Code Mobile Phone Number

Male Female ____/____/_____ Single Married _____ (_____)_____

(Circle one) Date of Birth (Circle one) Name of Spouse Spouse Phone number

Occupation:_____ (_____)_____

School Name if Student Employer Work Phone number

Email Address:_____ How were you referred to Pritchette PT? _____

Insurance Information

_____ (_____)_____ _____ _____

Insurance Company Ins. Co. Phone Number Policy ID Number Group Number

_____ ____/____/_____ _____

Policy Holder's Name Date of Birth Relationship to Patient

Worker's Compensation Information

_____

Worker's Compensation Carrier Address: Street City, State Zip

_____ _____ (_____)_____

Claim Number Case Manager Case Manager Phone Number

____/____/_____ _____ (_____)_____

Date Of Injury Employer at time of injury Employer Phone Number

Release of Information

I give permission to Pritchette Physical Therapy to release information to my insurance company, attorney, assignees, and/ or beneficiaries.

Assignment of Benefits

I authorize payment directly to Pritchette Physical Therapy for service I receive. Any payments made to me by third party payer services provided by Pritchette Physical Therapy will be immediately (within 5 days) transferred to Pritchette Physical Therapy.

Payment Guarantee

In consideration of the services rendered and to be rendered to the above named patient by Pritchette Physical Therapy, I expressly guarantee payment of this account and agree to pay any charges left unpaid in whole or in part by the insurance company. Should this account proceed to collection agency or court, I will be responsible for both the cost of billed services, as well as cost of collections and any and all attorney and court fees associated with the collections process. The patient is ultimately responsible for account total and balances.

_____

Signature of Responsible Party or Legal Guardian If Minor Date

By signing above, you as the patient or legal guardian, agree to the terms and conditions listed under "Release of Information", "Assignment of Benefits", and "Payment Guarantee". **Any unilateral alteration, strikeover or modification to the preprinted text or line entries of this document and legal agreement shall be of no effect whatsoever, and at Pritchette Physical Therapy's sole discretion, may render this document invalid.**

Pritchette Physical Therapy
orthopedic & sports rehabilitation
aquatic therapy • sports performance

Medical History Form

Personal Information

Name: _____ Date: _____
DOB: _____ Sex: _____
Is your injury work-related, the result of a motor vehicle accident, or fault of someone else?
_____
Have you hired an Attorney for the accident? _____

History

Exercise Frequency: _____ Exercise Type(s): _____
Do you smoke? _____ Have you ever smoked? _____ How Often? _____
Are you pregnant? _____ Do you have a Pacemaker? _____
Allergies: _____
What medications are you currently taking? _____
_____
Previous complaints/surgeries: _____
Previous diagnoses/medications: _____

Complaint

What is your major complaint? _____
Start date: _____ Possible cause: _____
Symptoms: _____
Previous doctors seen for complaint: _____
Previous treatment for complaint: _____
Symptom-Aggravating factors: _____
Symptom-Relieving factors: _____
Time of day symptoms are best: _____
Time of day symptoms are worst: _____
Current duration of pain: ☐ Intermittent ☐ Constant ☐ With certain motions
Current level of pain: ☐ Mild ☐ Moderate ☐ Severe ☐ Excruciating
Is your pain getting better or worse? _____ Have you had this injury before? _____

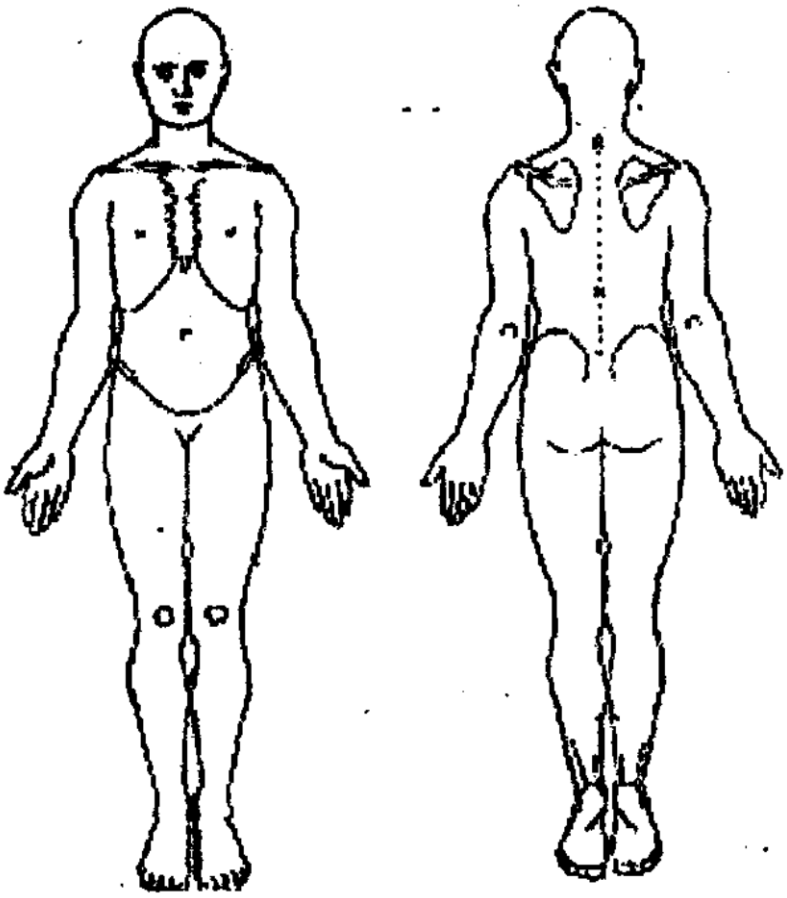
Do you have any of the following today? (Check all that apply)

☐ AIDS/HIV	☐ Anemia	☐ Angina	☐ Arteriosclerosis
☐ Arthritis	☐ Asthma	☐ Blood Clots	☐ Bone Infection
☐ Cancer	☐ Chemical Dependency	☐ Circulation Problems	☐ Depression
☐ Diabetes	☐ Epilepsy	☐ Eye Infection	☐ Heart Problems
☐ Hemophilia	☐ High/Low Blood Pressure	☐ Joint/Bone Infection	☐ Liver Problems
☐ Lung Issues	☐ Multiple Sclerosis	☐ Musculoskeletal Problems	☐ Pneumonia
☐ Stroke	☐ STD	☐ Tuberculosis	☐ Urinary Infection

_____ _____
Signature Date

Date:_____ Patient Name:_____

Please mark the diagram with “xx” where your pain typically presents:



On a scale of 1 to 10, (1 being minimal pain and 10 being excruciating), please rate your overall pain:

at worst: _____
at best: _____
on average: _____

Pritchette Physical Therapy
orthopedic & sports rehabilitation
aquatic therapy • sports performance

CLINIC AND PATIENT RESPONSIBILITIES & ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

IT IS THE PATIENT RESPONSIBILITY:

____ Int. Patients need to know and understand their insurance policy/policies. Patients should be aware of benefit coverage including which healthcare providers are contracted with their plan, covered and non-covered benefits, authorization requirements, and cost share information such as deductibles, co-insurance and co-payments. If you are not familiar with your plan coverage, we recommend that you contact your carrier directly.

____ Int. **To obtain a referral from their Referring Physician and/or obtain authorization for treatment from their insurance carrier prior to receiving services. Any non-covered services are the financial responsibility of the patient.**

____ Int. To pay the co-payment, deductibles, and coinsurance at the time of service.

____ Int. **To notify Pritchette Physical Therapy of cancellations as soon as possible. If a cancellation is received less than 24 hours or you are a no show for a scheduled visit, Pritchette Physical Therapy reserves the right to charge you $25.00 for these types of cancellations and/or no show.**

IT IS PRITCHETTE PHYSICAL THERAPY RESPONSIBILITY:

- To provide quality medical care.
- To file insurance claims for our patients. Claims are filed with insurance carriers no less than 3x/week.
- To send patient statements periodically during treatment and balance is due upon receipt of statements.

FINANCIAL POLICY ACKNOWLEDGEMENT AND ASSIGNMENT OF BENEFITS:

I have read and understand the above financial policy. I understand that, regardless of my insurance claim status or absence of insurance coverage, I am ultimately responsible for the balance on my account for any services that were rendered. If I receive insurance payments directly from my insurance, I will immediately sign over the check to Pritchette Physical Therapy.

My signature acknowledges receipt of HIPAA compliant Notice of Privacy Practices. I will receive a copy only when I request one.

Patient or Responsible Party Signature DATE

Printed Patient Name

4730 E. WARNER RD., SUITE 5 PHOENIX, AZ 85044 OFFICE: (480) 785-5415 OPTION 1 FAX: (480) 785-5761
1331 E. CHANDLER BLVD. SUITE 102 PHOENIX, AZ 85048 OFFICE: (480) 785-5415 OPTION 2 FAX: (480) 687-0467

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 is posted in the office.

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 is available from the U.S. Department of Health and Human Services. www.hhs.com

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be sorted 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 the policy of this office to remind patients of their appointments. We may do this by telephone, email, 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 that 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
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
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 accordance with state and federal laws.
8. We may change, add, delete, or modify any of these provisions to better serve the needs of the both the practice 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, _____ date _____ 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.

Pritchette Physical Therapy

orthopedic & sports rehabilitation

aquatic therapy • sports performance

Dry Needling Consent Form

Dry Needling (DN) involves placing a small needle into the muscle at the trigger point which is typically in an area which the muscle is tight and may be tender with the intent of causing the muscle to contract and then release, improving the flexibility of the muscle and therefore decreasing the symptoms. The performing therapist will not stimulate any distal or auricular points during the dry needling treatment. DN is a valuable treatment for musculoskeletal related pain such as soft tissue and joint pain, as well as to increase muscle performance. Like any treatment, there are possible complications. While these complications are rare in occurrence, it is recommended you read through the possible risks prior to giving consent to treatment.

Risk of the Procedure:

Though unlikely there are risks associated with this treatment. The most serious risk associated with DN is accidental puncture of a lung (pneumothorax) If this were to occur, it may likely only require a chest X-ray and no further treatment as it can resolve on its own. The symptoms of pain and shortness of breath may last for several days to weeks. A more severe lung puncture can require hospitalization and re-inflation of the lung. This is a rare complication and in skilled hands should not be a concern. If you feel any related symptoms, immediately contact your DN provider. If a pneumothorax is suspected, you should seek medical attention from your physician or, if necessary, go to the emergency room.

Other risks may include bruising, infection, and nerve injury. Please notify your provider if you have any conditions that can transferred by blood, require blood anticoagulants or any other conditions that may have an adverse effect to needle punctures. As the needles are very small and do not have a cutting edge, the likelihood of any significant tissue trauma from DN is Minimal.

Please Consult with our practitioner if you have any questions regarding the treatment above.

Do you have any known disease or infection that can be transmitted through bodily fluids?

[ ] Yes [ ] No

*If you marked yes, please discuss with your practitioner

_____

Print your name

_____ _____

Signature Date