

**FOOTHILLS ORTHOPEDIC & SPORT THERAPY, P.C.**  
**Ray Physical Therapy is a division of Foothills**

**FINANCIAL POLICY**

We want to welcome you to **Foothills Orthopedic and Sport Therapy P.C.** We are committed to having your treatment be successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment. No question is too small to ask, whether it is about your treatment, insurance, or financial information. A copy of this is available upon request.

As a service to you we will bill your **primary insurance only** & you will need to give us complete insurance information along with a copy of your card. We no longer bill secondary insurances. **We do require your co-payments be paid at time of service.** Your insurance policy is an agreement between you and your insurance company. We are not a party to that contract. We base our treatment plan on our professional judgment & not on what your insurance company will pay. Therefore all charges are ultimately your responsibility.

**Minor Patients**

The parent or guardian accompanying a minor is responsible for payment of services. Unaccompanied minors (under 18) will be denied non-emergency treatment, unless the parent or guardian has signed patient information and financial responsibility forms.

**Rebill Fee**

A Rebill fee of \$10.00 will be charged to your account each time we have to send an additional statement for the patient portion due.

**Missed Appointments**

Please cancel your appointment at least 24 hours in advance. If repeated cancellations or no shows occur, you will be charged \$25.00 for each missed appointment.

**Collections**

If your account becomes delinquent, collection proceedings will occur and you will be liable for any collection fees, attorney fees and court costs.

**Financial Authorization**

I hereby authorize direct payment of medical benefits to **Foothills Orthopedic and Sport Therapy, P.C.** I have read and understand the above financial policy, and I agree to be responsible for any balances not covered by my insurance. My signature below authorizes this office to release medical information to my insurance company only to assist with any outstanding balances on my account.

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**PATIENT OR GUARDIAN SIGNATURE**

## HISTORY & PHYSICAL

Please be accurate and complete as some treatment programs and procedures may be based on this information.

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ SPORTS/HOBBIES: \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_

Send a copy of our Evaluation to him/her? Yes/No

CURRENT MEDICATIONS WITH DOSAGES INCLUDE VITAMINS, OVER-THE-COUNTER, & SUPPLEMENTS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

ALLERGIES:(include latex/tape) \_\_\_\_\_

MEDICAL HISTORY: (Circle any that apply)

Diabetes

Pregnant

Hypertension

Hepatitis

Asthma

Arthritis

Blood Clots

Cancer

Heart Disease

Epilepsy/Seizure Disorder

Multiple Sclerosis

Lupus

Tuberculosis

Pain Stimulators/Pump

Pacemaker

Other \_\_\_\_\_

LIST RECENT SURGERIES AND ALL SURGERIES FOR THIS PROBLEM:

\_\_\_\_\_

Special Tests: X-ray MRI CT Scan EMG Nerve Conduction

Have you received Therapy before: Yes / No For this problem: Yes / No

Have you been advised by a physician to avoid any exercise? Yes / No

Do you have legal paperwork instructing your healthcare providers to “Do Not Resuscitate or (DNR)”? \_\_\_\_\_ If yes, please provide us with a copy.

PATIENT SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

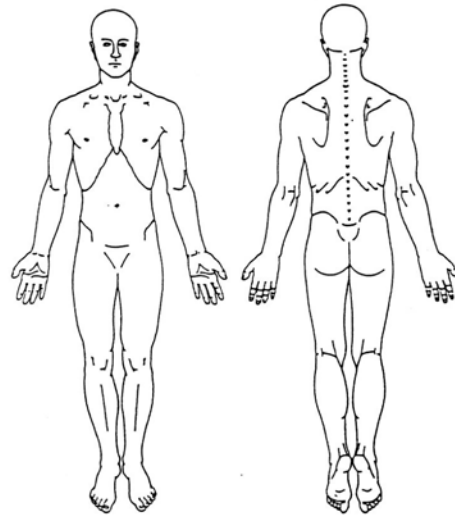
# PAIN ASSESSMENT

**Patient Name:** \_\_\_\_\_ **Your Chief Complaint** \_\_\_\_\_

On the Body Diagram please **mark** the area(s) where you have pain.

Indicate your pain type by **circling** a letter or letters:

- A) Deep (inside)
- B) Constant
- C) Intermittent
- D) Aching
- E) Burning
- F) Shooting/Radiating
- G) Sharp
- H) Dull
- I) Other: \_\_\_\_\_



Rank your pain level(s) on the number scale by **circling** the level of pain you have felt recently.

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10  
(no pain) (emergency room pain)

What are you having difficulty doing at home or work because of this current problem?

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What are your goals for Physical Therapy? (For example: learn to control pain, return to usual activities, etc?) \_\_\_\_\_

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**THERAPIST SIGNATURE:** \_\_\_\_\_ **Date:** \_\_\_\_\_

PT: \_\_\_\_\_ DX: \_\_\_\_\_

**PERSONAL INFORMATION**

DATE: \_\_\_\_\_ REFERRING DOCTOR: \_\_\_\_\_

LAST NAME: \_\_\_\_\_ FIRST \_\_\_\_\_ M.I. \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ SEX: M / F BIRTH DATE: \_\_\_\_\_

MARITAL STATUS: M S D W ARE YOU UNDER 18? YES / NO

EMPLOYER: \_\_\_\_\_ RETIRED: YES/NO

DATE OF INJURY: \_\_\_\_\_ AUTO: YES / NO WORKERS COMP: YES / NO

**POLICYHOLDER INFORMATION**

NAME OF INSURED: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

SS#: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

**INSURANCE INFORMATION**

INS COMPANY: \_\_\_\_\_

**PRIVACY NOTICE**

We at Foothills Orthopedic & Sport Therapy, P.C. feel that your privacy should be protected. In the course of your treatment, we collect personal information about you that is necessary to treating you. As our valued patient, we treat this information as confidential and recognize the importance of protecting it. A copy of our complete HIPPA Notice of Privacy Practices is available upon request. By signing below, I acknowledge that I have been permitted to access and/or have a copy of this information.

I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while a patient at **FOOTHILLS ORTHOPEDIC & SPORT THERAPY, P.C. (RAY PHYSICAL THERAPY IS A DIVISION OF FOOTHILLS)**

\_\_\_\_\_  
SIGNATURE OF PATIENT OR GUARDIAN

\_\_\_\_\_  
DATE