Foothills Orthopedic & Sport Therapy, P.C.

APPT. DATE: _____REFERRING DOCTOR: _____FAMILY DOCTOR: _____

LAST NAME: _____ FIRST_____ M.I._____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____CELL PHONE: _____

BEST CONTACT NUMBER : HOME/WORK/CELL E-MAIL ADDRESS: _____

BIRTH DATE: _____ SEX: M / F MARITAL STATUS: M S D W RETIRED: YES/NO

SOCIAL SECURITY #: _____ OCCUPATION/EMPLOYER: _____

IS YOUR CONDITION DUE TO AN ACCIDENT? YES/NO DATE OF INJURY: _____

TYPE OF ACCIDENT: AUTO/WORK/HOME INSURANCE NAME AND CLAIM#:_____

ADJUSTER'S NAME & CONTACT NUMBER: _____

INSURANCE & POLICYHOLDER INFORMATION

INSURANCE COMPANY: _____

NAME OF INSURED: _____ RELATIONSHIP: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ PHONE: _____

SS#: _____ DATE OF BIRTH: _____ EMPLOYER: _____

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 for treating you. As our valued patient, we treat this information as confidential and recognize the importance of protecting it. A copy of our complete HIPAA 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.**

SIGNATURE: _____ **DATE**: _____

(PATIENT OR GUARDIAN)

HISTORY & PHYSICAL/PAIN ASSESSMENT

PATIENT NAME: _____ CHIEF COMPLAINT: _____

MEDICATIONS (prescribed and over the counter – including name, dosage, frequency, & how it is administered): _____

_____

_____

ALLERGIES (include latex/tape): _____

MEDICAL HISTORY: (Circle any that apply)

High Blood Pressure	Speech Problems	Currently Pregnant
Cardiac Conditions	Strokes	Asthma
Cardiac Pacemaker	Seizure Disorder	Blood Clots
Circulation Problems	Allergies	Multiple Sclerosis
Osteoporosis	Kidney Problems	Tuberculosis
Arthritis	Gall Bladder Problems	Hepatitis
Diabetes	Depression	Pain Stimulators/Pump
Cancer	Anxiety	Epilepsy
Dizzy Spells	Fractures	Lupus
Vision Problems	Metal Implants	Other _____

LIST RECENT SURGERIES AND ALL SURGERIES FOR THIS PROBLEM:

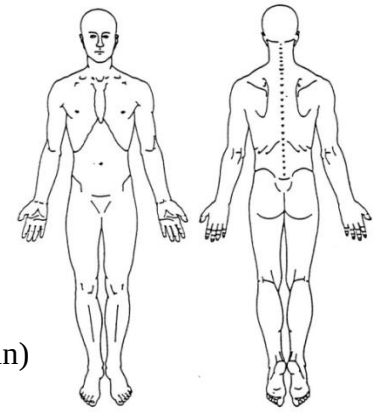
_____

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

Have you received Therapy before? **Yes / No** For this problem? **Yes / No**

Do you have legal paperwork instructing your healthcare providers to "**Do Not Resuscitate or (DNR)"**? **Yes / No** If yes, please provide us with a copy.

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



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)

FOOTHILLS ORTHOPEDIC & SPORT THERAPY, P.C.

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 insurance if you give us your complete information along with a copy of your card. **We do require your co-payments and deductible 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 both the consent for treatment and financial responsibility.

Terms:

All outstanding balances over 60 days are subject to a finance charge of 1.5% per month.

Missed Appointments

Please cancel your appointment at least 24 hours in advance to avoid a cancellation fee of $25.00 for each missed appointment. Three No Show appointments will result in discharge from services.

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**