FOOTHILLS
SPORTS MEDICINE
PHYSICAL THERAPY

PATIENT REGISTRATION FORM

Please Print

Patient Name:_____ Gender: ☐ Male ☐ Female

Birth Date:_____ Age:_____ Social Security #:_____

Address:_____ City, State, Zip:_____

Home Phone #:_____ Cell Phone #:_____

Email:_____

If under 18, Parent/Guardian:_____ Relationship to Patient:_____

Parent/Guardian Social #:_____ Parent/Guardian Birth Date:_____

Would you like to receive appointment reminders via: ☐ Email ☐ Text (must select provider below)

ALLTel	Cricket Wireless	Quest	Verizon
AT&T	Metrocell	Sprint PCS	Virgin Mobile
Boost Mobile	MetroPCS	T-Mobile	
Cingular	Nextel	US Cellular	

Emergency Contact:_____ Relationship/Phone:_____

Do you have a prescription from a physician or provider for physical therapy? ☐ Yes ☐ No

If yes, who is the referring physician?_____ Return to Doctor Date?_____

How did you hear of Foothills Sports Medicine Physical Therapy?

☐ Friend/Family/Acquaintance	☐ Free Injury Screening	☐ Location/Signage
☐ Former Patient	☐ Foothills Employee	☐ Advertisement
☐ Website/Social Media	☐ Insurance Company/Employer	☐ None, Physician Referred
☐ FAST Client	☐ Sports Club/Coach	

Are you seeking Physical Therapy because of a sports injury through a school or club sport? ☐ Yes ☐ No

School/Team Name:_____

Are you seeking Physical Therapy because of a Work-Related Accident? ☐ Yes ☐ No

Employer Name:_____ Phone:_____

Employer Address:_____

INSURANCE INFORMATION *(To be completed even if insurance card on file)*

Primary Insurance	**Secondary Insurance**
Insurance Co Name:_____	Insurance Co Name:_____
Policy Holder:_____	Policy Holder:_____
Policy Holder Birth Date:_____	Policy Holder Birth Date:_____
Relationship to Patient:_____	Relationship to Patient:_____

Patient/Guardian Signature:_____ Date:_____

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PATIENT MEDICAL HISTORY FORM

Patient Name: _____ Gender: ☐ Male ☐ Female Date: _____

Referring Physician: _____ Return Visit Date: _____

Body Part: _____ Date of Injury: _____ Date of Surgery: _____

Occupation: _____ Work Status: ☐ FT ☐ PT ☐ Unemployed

Hobbies: _____ Prior Treatment: _____

Height: _____ Weight: _____

What is the nature of the current injury?

☐ Work Related ☐ Chronic/Reoccurring ☐ Fall ☐ MVA

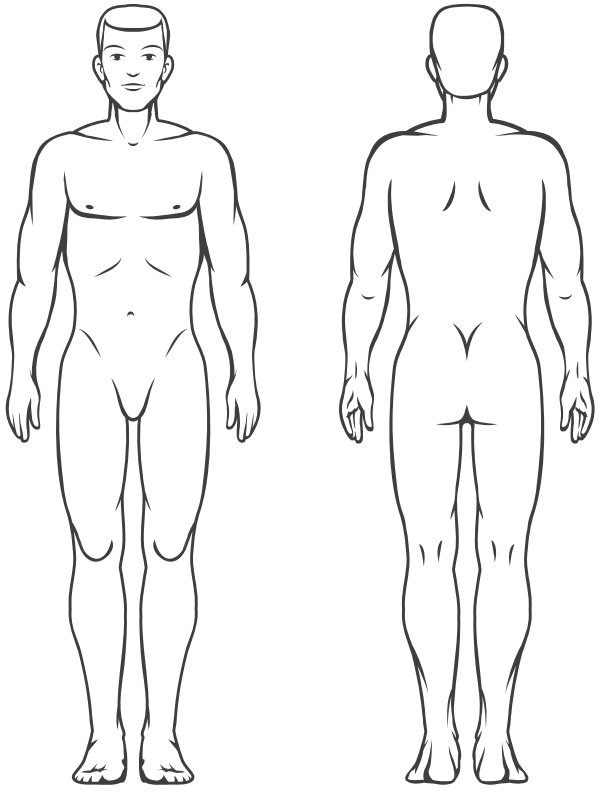
☐ Recreational ☐ Lift or Carry ☐ Insidious ☐ Surgery

What is your pain rating in the last 24 hours? 0-10 Numeric Pain Rating Scale

0 1 2 3 4 5 6 7 8 9 10

NO PAIN WORST POSSIBLE PAIN

Please use the diagram provided to mark where your symptoms are currently.



Symbols to Use

Aching: Δ Δ Δ
Stabbing: / / /
Pins & Needles: ○○○
Burning: X X X
Numbness: = = =
Radiates: →→→

My symptoms are made better by: _____

_____

My symptoms are made worse by: _____

_____

My symptoms are:

☐ Constant ☐ Intermittent ☐ Chronic ☐ New

Are your work or activities of daily living limited?

☐ Yes ☐ Partial ☐ No

In addition to this paperwork, you will complete a functional outcomes scale.

PATIENT MEDICAL HISTORY FORM (CONTINUED)

What is your goal for physical therapy? _____

How often do you exercise more than 20 minutes per day?

☐ 1x/wk ☐ 2x/wk ☐ 3x/wk ☐ 4x/wk ☐ 5x/wk ☐ 6x/wk ☐ 7x/wk

Do you smoke? ☐ Yes ☐ No

List any recent Diagnostics (*Xray, MRI, CT Scan, EEG, EMG, Injections*): _____

_____

Do you have any allergies to latex, cold, heat or medications? ☐ Yes ☐ No If yes: _____

Are you on any medications? ☐ Please see attached list provided by the patient.

_____ _____ _____

_____ _____ _____

Are you on any blood thinners? ☐ Yes ☐ No INR: _____

Have you had Home Health Care or a stay with an Inpatient Facility in the last 30 days? If so, please state where:

_____

Have you been discharged? ☐ Yes ☐ No What was the date you were discharged from care? _____

Have you fallen in the last year? ☐ Yes ☐ No If yes, how many times? _____

Did you sustain an injury when you fell, and if so, please describe: _____

Under what circumstances did you fall? (e.g. location, using assistive device, transferring, etc.) _____

_____

Past Medical History

Have you recently noted any of the following? (*check all that apply*)

☐ Changes in Bowel or Bladder
☐ Constipation
☐ Difficulty Swallowing
☐ Dizziness/Lightheaded
☐ Fainting
☐ Fatigue
☐ Fever/Sweats/Chills
☐ Hearburn/Indigestion
☐ Incontinence
☐ Muscle Weakness
☐ Nausea/Vomiting
☐ Numbness/Tingling
☐ Pain that wakes you at night
☐ Rapid Heart Rate/Palpitations
☐ Recent Onset of Headaches
☐ Shortness of Breath
☐ Unexplained Weight gain/loss
☐ Unexplained Cough
☐ Visual Changes
☐ Prior surgeries. Please describe: _____

Have you ever been diagnosed with any of the following? (*check all that apply*)

☐ Anemia
☐ Asthma
☐ Back Pain *(Degenerative, Stenosis, Herniation)*
☐ Bladder/Urinary/Kidney Disease
☐ Bone/Joint infections
☐ Cancer *(any)*
☐ Chest Pain or Angina
☐ Chronic Headaches
☐ Congestive Heart Failure/Heart Attack
☐ Depression/Anxiety/Panic Disorders
☐ Diabetes Type I/Type II
☐ GI Disease *(Liver, Ulcer, Hernia, Reflex, Gall Bladder)*
☐ High/Low Blood Pressure
☐ Lung Disease/COPD/ARDS
☐ Neurological Disease *(MS, Parkinson's)*
☐ Osteoarthritis/Rheumatoid Arthritis
☐ Pneumonia
☐ Seizures or Epilepsy
☐ Stroke/CVA/TIA
☐ TB/HIV/Hepatitis A,B,C
☐ Thyroid Condition
☐ Vascular/Circulation Problems/ Blood Clots
☐ Visual or Hearing Impairments
☐ Osteoporosis

The above information I have provided is complete, true and correct to the best of my knowledge.

Patient/Guardian Signature: _____ Date: _____

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PATIENT INFORMATION AND CONSENT FORM

CONSENT FOR CARE AND TREATMENT: I hereby agree and give my consent to Foothills Sports Medicine Physical Therapy to furnish appropriate rehabilitative care and treatment, as considered necessary and in the best interest in order to attend to the physical condition. I understand that the benefits and risks to all interventions will be explained and that the patient holds the final judgment in such matters.

MEMBER DIRECT PAYMENT NOTIFICATION: Arizona state constitution permits you to pay a healthcare provider for health care services directly. If you have any active health insurance coverage, please review the provider's policies regarding payment before you make any arrangements to pay directly.

AUTHORIZATION TO PAY: I hereby authorize insurance payment directly to Foothills Sports Medicine Physical Therapy, Billing Department, 15410 S. Mountain Pkwy. Suite 112, Phoenix, AZ 85044 for medical services rendered. I understand that I am financially responsible for the charges not covered by my insurance. In the event of default, I promise to pay collection costs and reasonable fees as may be required to obtain collection of this account.

ATTENDANCE AGREEMENT: Due to the nature of physical therapy, your progress and full recovery are dependent on both our experienced physical therapists, and your active participation and commitment to your appointments. If you need to cancel your appointment, please contact Foothills Sports Medicine at least one day prior to your appointment. If you call to cancel your appointment on the same day as your appointment or if you do not show, a $25.00 cancellation fee will be assessed.

WORKERS' COMPENSATION PATIENTS: We are required to inform your Workers' Compensation Adjuster and/or Rehabilitation Manager of all missed or canceled appointments. It is also required that all missed visits be rescheduled.

PHOTOGRAPHY/VIDEOGRAPHY AGREEMENT: I understand that in order to protect the confidentiality of our patients, there can be no filming, going "live" via social media or taking pictures of my treatment, or that of other patients, without prior authorization from the Clinic Director.

AUTHORIZATION TO COMMUNICATE ELECTRONICALLY: I understand that authorized personnel (including my physical therapist) from Foothills Sports Medicine Physical Therapy may communicate with me regarding scheduling/ appointments, the treatment provided, home exercise programs, and educational/informative content as it relates to my condition. I understand that my protected health information (PHI) will not be communicated electronically. I understand that I have the opportunity to opt-out of future communications at any time using the "unsubscribe" option on any communication via text or email.

By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document.

Printed Name:_____ Date:_____

Patient/Guardian Signature:_____ Date:_____

NOTICE OF PATIENT INFORMATION PRACTICES

This notice describes how medical information about you may be used or disclosed and how you can get access to information. Please review it carefully.

FOOTHILLS SPORTS MEDICINE PHYSICAL THERAPY'S LEGAL DUTY

Foothills Sports Medicine Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow these practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Foothills Sports Medicine Physical Therapy uses your personal health information primarily for treatment; obtaining payment of treatment; conducting internal administrative activities, and evaluating the quality of care that we provide. For example, Foothills Sports Medicine Physical Therapy may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Foothills Sports Medicine Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Foothills Sports Medicine Physical Therapy's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization through a written statement to stop future disclosures at any time.

Foothills Sports Medicine Physical Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the clinic and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate information or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Foothills Sports Medicine Physical Therapy will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Foothills Sports Medicine Physical Therapy may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact the person(s) listed below. You will not be retaliated against for filing a complaint.

Compliance Department
15410 South Mountain Parkway, Suite 107
Phoenix, AZ 85044
888-402-7091

Department of Health and Human Services
Mail, fax, email, or OCR Complaint Portal
www.hhs.gov/ocr/hipaa/

PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand Foothills Sports Medicine Physical Therapy's Notice of Information Practices.

- I understand that Foothills Sports Medicine Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and 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 Foothills Sports Medicine Physical Therapy will consider requests for restriction on a case by case basis.
- I hereby consent to the use and disclosure of my personal health information for purposes as noted in Foothills Sports Medicine Physical Therapy's Notice of Information Practices.
- I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Printed Name:_____ Date:_____

Patient/Guardian Signature:_____ Date:_____

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Printed Name:_____ Date:_____

Patient/Guardian Signature:_____ Date:_____