ARCH
PHYSICAL THERAPY
& SPORTS MEDICINE

New Patient Check List

Please arrive 15 minutes before your scheduled appointment time with your drivers license/photo ID, insurance cards, and the following completed documents:

- Welcome Letter
- Cancellation Policy
- Release of Information
- Consent for Testimonial Release and Marketing
- Medical History Form
- Medication List
- Patient Data Sheets (3 pages)
- Consent Form
- Medicare Secondary Payer Questionnaire
- Fall Risk Questionnaire
- Disability Index (Pain Questionnaire)

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WELCOME TO ARCH PHYSICAL THERAPY

We are happy you have chosen us to be your physical therapy provider! We hope you will find your experience at ARCH to be far above your expectations. Each therapist has over 20 years of experience in orthopedics and manual therapy and an excellent record of providing results with their patients.

A few things to keep in mind that will make your therapy experience go smoothly:

- Please arrive at your scheduled appointment time. We spend 1 on 1 time with every patient and timeliness is essential for you to receive your treatment and others to receive theirs.
- Please call if you are going to be more than 15 minutes late for your appointment.
- It is important that you keep ALL your scheduled appointments. Physical therapy is your "physical medicine" and it is important to attend all your sessions to get the best results for long term success.
- Please make your co-pay before each treatment. As a courtesy to you, we verify all insurances before your first appointment to advise you of any possible out of pocket expenses. It is ultimately the patient's responsibility to know their insurance coverage. Payment arrangements can be made in advance for patients that qualify.
- Failure to show for 3 appointments will result in your discharge from physical therapy. Excessive cancellations (more than one a week) may result in your discharge from physical therapy. Kindly give no less than 24 hours notice of any cancellations to avoid a $25 cancellation fee. You may leave a message if canceling after normal business hours. We will make every attempt to reschedule that appointment.
- Notify your therapist if there are any changes in your health or insurance.

Thank you for choosing ARCH Physical Therapy and Sports Medicine. If you have any questions, concerns or feedback, please do not hesitate to let us know.

_____ _____

Patient Signature Date

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CANCELLATION/NO SHOW FEE POLICY

(Medicare Patients Only)

You play an integral role in the success of your treatment. Your therapist will establish an individual treatment plan for you, including recommendations for frequency and number of treatment visits. Your dedication to attending the recommended number of treatments is vital to ensure progress with your therapy program.

We expect you to keep all of your appointments. However, we understand there may be circumstances in which you may need to cancel or reschedule an appointment.

PLEASE PROVIDE AT LEAST 24 HOURS NOTICE FOR CANCELLATIONS OR FOR RESCHEDULING AN APPOINTMENT.

I HAVE READ AND FULLY UNDERSTAND THE “CANCELLATION/NO SHOW FEE POLICY” STATED ABOVE, AND I AGREE TO ADHERE TO SUCH POLICY.

_____ _____

Patient Signature Date

_____

Patient Printed Name

ARCH PHYSICAL THERAPY PATIENT DATA SHEET

First: **MI:** **Last:**

Date of Birth: **Age:** **Gender:** Male ☐ Female ☐

Physical Address:

Mailing Address:

Phone Numbers: **OK To Call** **Best Time To Call**

Home: ☐

Work: ☐

Cell: ☐

May we send you text messages for your appointment reminders to the number(s) listed above? ☐ Yes ☐ No

May we send you text messages for Marketing Materials, including Patient review requests to the number(s) listed above? ☐ Yes ☐ No

By marking "Yes" above, you understand that text messages may NOT be secure, with a risk of unauthorized access to your information

May we send you emails relating to your care with us? ☐ Yes ☐ No

By providing your email address below, you understand that email communications may NOT be secure, with a risk of unauthorized access to your information.

Email:

Preferred language: **Interpreter required?** ☐ Yes

Date of Injury: **Referring Physician:**

Injury Area: **Auto or Work Accident:** ☐ Auto ☐ Work ☐ N/A

State Where Accident Occured:

Are you currently receiving or have you received Home Health Services (including any therapy, nursing, bathing & dressing, etc) in the last 60 days? ☐ Yes ☐ No

Are you currently receiving or have you received other therapy services in the last 60 days? ☐ Yes ☐ No

Marital Status:

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown

Student Status:

☐ Full-Time ☐ Part-Time ☐ None

EMPLOYMENT STATUS

Employment Status:

☐ Active Military ☐ Full-Time ☐ None ☐ Part-Time ☐ Retired ☐ Self Employed

Employer: **Occupation:**

Address:

Phone:

Employer: **Occupation:**

Address:

Phone:

INSURANCE INFORMATION

Primary Insurance:

Policy Holder's Name: **Holder's Birth Date:**

Policy or Certificate #: **Group #:**

Policy Holder's Employer:

Secondary Insurance:

Policy Holder's Name: **Holder's Birth Date:**

Policy or Certificate #: **Group #:**

Policy Holder's Employer:

How did you hear about us?

- ☐ Physician
- ☐ Employer
- ☐ Case Manager
- ☐ Former Patient
- ☐ Adjustor
- ☐ School
- ☐ Hospital
- ☐ Cross Referral
- ☐ Friend - Word of Mouth
- ☐ Attorney
- ☐ Self
- ☐ Screens - Open Houses
- ☐ Marketing Ad - Print
- ☐ Marketing Ad - TV
- ☐ Marketing Ad - Billboard
- ☐ Marketing Ad - Direct Mail - Email
- ☐ Marketing Ad - Facebook
- ☐ Marketing Ad - Other

Specify if other :

Note: Please provide us with the most updated information below.

EMERGENCY AND OTHER CONTACTS

Name	Phone	Work	Cell	Fax	Type

DISCLOSURE OF MEDICAL RECORDS

I authorize the following individuals to have access to my medical and billing records:

Name Relationship

Name Relationship

Signature of Patient

Date

PATIENT INTAKE AND CONSENT FORM

Internal Use Only: A/C# Name A/C Type Office #

CONSENT TO TREATMENT

I consent to rehabilitation and related services at: ARCH PHYSICAL THERAPY

In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature. **Initials:**_____

TREATMENT OF MINORS

I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. **Initials:**_____

LIABILITY

I know and agree that: ARCH PHYSICAL THERAPY is not responsible for loss or damage to personal valuables. **Initials:**_____

WAIVER AND RELEASE

I hereby release, discharge and acquit: ARCH PHYSICAL THERAPY its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. **Initials:**_____

AUTHORIZATION OF PAYMENT

I hereby assign all benefits directly to: ARCH PHYSICAL THERAPY
I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice Of Privacy Practices. **Initials:**_____

FINANCIAL POLICY

I understand fully that, in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

To assist in establishing your account, please:

- Supply all necessary information for accurate billing of your claim, including your insurance card, driver's license, employer information, and demographic information.
- Satisfy all insurance co-payments, co-insurance, deductibles, and non-covered services on the day services are rendered.
- Provide your insurance company and us with any additional information requested to complete the processing of claims filed on your behalf. **Initials:**_____

NOTICE OF PRIVACY/PATIENT BILL OF RIGHTS

I acknowledge receipt of Notice of Privacy Practices. **Initials:**_____
I acknowledge receipt of the Statement of Patient Rights. **Initials:**_____

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature _____ **Witness Signature** _____ **Date** _____

Medical History Form

Patient Name:	**Today's Date:**	
Referring Physician:	**Date of Birth:**	**Age:**
Primary Care Physician:	**Date of Injury or Onset:**	
Date of Next Physician Appointment:		

Reason for Therapy:

Cause of Injury or Onset: ☐ Accident ☐ Auto ☐ Work ☐ Other: **If Other, please explain**:

Have you been hospitalized for the present condition? ☐ Yes ☐ No **If Yes, date**:

Did you have surgery for this condition? ☐ Yes ☐ No **If Yes, date**:
If Yes, surgery type:

Are you currently receiving any other care for the condition mentioned above? ☐Yes ☐No
If Yes, please describe:

Have you ever received therapy in the past for the condition mentioned above? ☐Yes ☐ No **If Yes, date:**
Describe previous treatment:

Previous Treatment: ☐Successful ☐Unsuccessful

Have you fallen in the last year? ☐ Yes ☐ No **If Yes, how many times?** **If Yes, were you injured?** ☐ Yes ☐ No
Do you feel unsteady when standing or walking? ☐ Yes ☐ No **Do you worry about falling?** ☐ Yes ☐ No

What are your personal goals/outcomes you hope to achieve from therapy?

Describe your general health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor	**Do you smoke or use tobacco?** ☐ Yes ☐ No

DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply)

☐ **Allergies** ☐ **Latex** ☐ **Other**	☐ **Dizziness**	☐ **Kidney Problems**
☐ **Anemia**	☐ **Epilepsy or Seizure Disorder**	☐ **Metal Implants**
☐ **Anxiety or Panic Disorders**	☐ **Fainting**	☐ **MRSA**
☐ **Arthritis** ☐ **OA** ☐ **RA**	☐ **Fatigue or Weakness**	☐ **Multiple Sclerosis**
☐ **Asthma**	☐ **Fever or Chills**	☐ **Nausea / Vomiting**
☐ **Use of Blood Thinners**	☐ **Fractures**	☐ **Osteoporosis**
☐ **Bowel or Bladder Disorder**	☐ **Headaches**	☐ **Pacemaker**
☐ **Bleeding Disorder**	☐ **Head Injury or Concussion**	☐ **Parkinson's Disease**
☐ **Cancer**	☐ **Hearing Impairment**	☐ **Peripheral Vascular Disease**
☐ **Chronic Cough**	☐ **Heart Disease or Heart Attack**	☐ **Respiratory or Breathing Problems**
☐ **COPD**	☐ **Hepatitis** ☐ **A** ☐ **B** ☐ **C**	☐ **Ringing in Ears**
☐ **Congestive Heart Failure**	☐ **Hernia**	☐ **Sexual Dysfunction**
☐ **Currently Pregnant**	☐ **Blood Pressure** ☐ **High** ☐ **Low**	☐ **Skin Abnormalities**
☐ **Deep Vein Thrombosis (DVT)**	☐ **HIV or AIDS**	☐ **Stroke or TIA**
☐ **Depression**	☐ **Hypoglycemia**	☐ **Thyroid Problems**
☐ **Diabetes** ☐**Type I** ☐ **Type II**	☐ **Hypersensitivity to Hot or Cold**	☐ **Tuberculosis**

List any other medical problems and explain:

Medical History Form

Medication List

Name of Medication	Dosage	Frequency	
☐ Check Box if Medication List provided separately.			
1.			☐ Injection ☐ Oral ☐ Topical ☐Other
2.			☐ Injection ☐ Oral ☐ Topical ☐Other
3.			☐ Injection ☐ Oral ☐ Topical ☐Other
4.			☐ Injection ☐ Oral ☐ Topical ☐Other
5.			☐ Injection ☐ Oral ☐ Topical ☐Other
6.			☐ Injection ☐ Oral ☐ Topical ☐Other
7.			☐ Injection ☐ Oral ☐ Topical ☐Other
8.			☐ Injection ☐ Oral ☐ Topical ☐Other
9.			☐ Injection ☐ Oral ☐ Topical ☐Other
10.			☐ Injection ☐ Oral ☐ Topical ☐Other
11.			☐ Injection ☐ Oral ☐ Topical ☐Other
12.			☐ Injection ☐ Oral ☐ Topical ☐Other

Over the Counter Medications (check all that apply): ☐ Aspirin/Ibuprofen ☐ Antacids ☐ Sleeping Aids ☐ Cold Medicine: ☐ Cough Medicine ☐ Allergy Relief ☐ Laxative ☐ Diet Pills ☐ Vitamins/Herbal Supplements ☐ Other:

Pain Scale

Rate the severity of your pain by circling a box on the following scale.

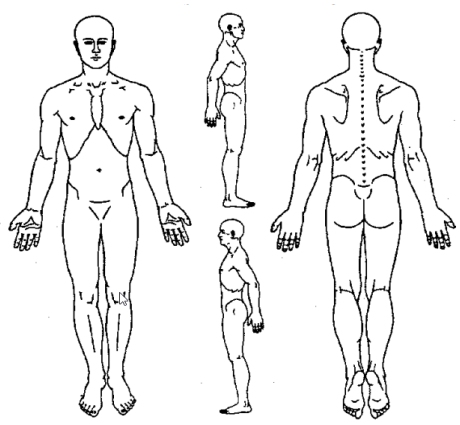
No Pain — Worst Pain

1	2	3	4	5	6	7	8	9	10

On the Body Diagram mark where you are experiencing symptoms, right now. Use the letters below to indicate the type and location.

KEY:

A = Aching B = Burning N = Numbness
P = Tingling S = Stabbing O = Other



Signature of Patient:	**DOB:**
Printed Name of Patient:	**Date:**

Patient Name: _____ Account #: _____

Medication List

Please provide us with a list of any and all medications you are currently taking including any over the counter medications such as vitamins, allergy relief, cold/cough medicine etc.

Name of Medication	Dosage	How Often	How it is Administered
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			

Patient Name: _____ Account #: _____

Name of Medication	Dosage	How Often	How it is Administered
11)			
12)			
13)			
14)			
15)			
16)			
17)			
18)			
19)			
20)			