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)

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

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 & SPORTS MEDICINE PATIENT DATA SHEET

DO NOT EMAIL The electronic form is provided for your convenience. With respect to responding to this form, please do not send via email. Please populate, print and sign a hardcopy that may be faxed, mailed or hand delivered to the clinic.

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

☐ Yes ☐ No

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

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 & SPORTS MEDICINE
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 & SPORTS MEDICINE is not responsible for loss or damage to personal valuables. **Initials:**___________

WAIVER AND RELEASE

I hereby release, discharge and acquit: ARCH PHYSICAL THERAPY & SPORTS MEDICINE 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 physician or urgent care services. Medical Technician, **Initials:**___________

AUTHORIZATION OF PAYMENT

I hereby assign all benefits directly to: ARCH PHYSICAL THERAPY & SPORTS MEDICINE
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 ____________________

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M5.002A

ARCH PHYSICAL THERAPY & SPORTS MEDICINE MEDICAL HISTORY FORM

PATIENT NAME: ______________________________ TODAY'S DATE: ______________
REFERRING PHYSICIAN'S NAME: ____________________ DATE OF INJURY OR ONSET: ________
PRIMARY CARE PHYSICIAN'S NAME: __________________ ARE YOU PRESENTLY WORKING? Y ES NO
CAUSE OF INJURY OR ONSET: _____________________ DATE OF NEXT MD APPT: __________

DO YOU CURRENTLY HAVE ANY "FLU TYPE" SYMPTOMS (I.E. FEVER, COUGHING)? YES NO
IF YES, WHAT SYMPTOMS: ____

DO YOU HAVE ANY OPEN CUTS, LESIONS OR WOUNDS? YES NO IF YES, WHERE: ____________

HAVE YOU FALLEN IN THE PAST YEAR? (circle one) YES NO IF YES, HOW MANY TIMES: ______

IF YES TO FALLING, DID YOU SUSTAIN AN INJURY AS RESULT OF THE FALL? YES NO __________

WHAT IS YOUR REASON FOR ATTENDING THERAPY: ________________________________

BECAUSE OF YOUR PROBLEM, WHAT SPECIFIC ACTIVITIES ARE YOU HAVING DIFFICULTY WITH?
1. ____
2. ____
3. ____

WHAT ARE YOUR PERSONAL GOALS/OUTCOMES YOU HOPE TO ACHIEVE FROM THERAPY?
1. ____
2. ____
3. ____

DESCRIBE YOUR GENERAL HEALTH: (circle one) EXCELLENT GOOD FAIR POOR

DO YOU USE TOBACCO? (circle one) YES NO, IF YES, HOW MUCH? ______ WEAR GLASSES / CONTACTS?: YES NO

HAVE YOU RECENTLY BEEN HOSPITALIZED OR HAD SURGERY? YES NO IF YES, WHEN__________
AND WHY____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY FOR THIS CONDITION? (circle one) YES NO
WHAT WAS DONE? / WHAT WERE THE RESULTS?:
____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY THIS CALENDAR YEAR? (circle one) YES NO
WAS IT RECEIVED AT: (circle one) HOSPITAL OUT PATIENT CENTER HOME HEALTH
FOR HOW LONG? ____

CURRENT MEDICATIONS: ____
____

ALLERGIES: Medication ________Reaction__________ Other __________Reaction______________
ARE YOU ALLERGIC TO LATEX? (circle one) YES NO If yes what is the Reaction_______________
Are you Allergic to Dexamethasone? YES NO If yes what is the Reaction____________________

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

□ ANEMIA
□ ARTHRITIS
□ CANCER
□ CARDIOVASCULAR PROBLEMS
□ HOLTER MONITOR - currently wearing?
□ PACEMAKER
□ HIGH BLOOD PRESSURE □ controlled □ uncontrolled
□ LOW BLOOD PRESSURE
□ CURRENTLY PREGNANT
□ DIABETES □controlled □uncontrolled
□ DEPRESSION
□ DIZZINESS/FAINTING
□ FRACTURES
□ HEADACHES
□ HEPATITIS/HIV
□ KIDNEY PROBLEMS
□ MRSA (Methicillin Resistant Staphylococcus Aureus)
□ OSTEOPOROSIS
□ RESPIRATORY PROBLEMS
□ ASTHMA □ controlled □ uncontrolled
□ COPD □ controlled □ uncontrolled
□ Other
□ SEIZURES □ controlled □ uncontrolled
□ THYROID PROBLEMS
□ BLOOD THINNERS (Anticoagulants)

If checked any above, explain: ____

☐ ANY OTHER MEDICAL PROBLEMS: ____

SIGNATURE OF PATIENT: __________________ REVIEWED BY Therapist: ______________Date__________

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CONSENT TO USE OF LIKENESS AND TESTIMONIAL AND RELEASE

I, ______________________________________, hereby consent to allow ARCH PHYSICAL THERAPY & SPORTS MEDICINE and its employees, agents, partners, and affiliates (collectively "Clinic"), to use my name, photograph, videotape/audiotape recording, and/or written testimonial ("marketing materials") in Clinic's marketing brochures, publications, and/or on their website and social media accounts, including but not limited to Facebook and Twitter, to promote the services offered by Clinic. I understand and agree that these marketing materials are owned by Clinic and will not be returned to me.

I hereby release, hold harmless, and forever discharge the Clinic from any and all claims, demands, and causes of action which I have or may have by reason of this authorization.

Further, I hereby affirm that I have read this Consent to Likeness and Release, and I fully understand the content, meaning, and impact of this agreement. This agreement shall be binding upon me and my heirs, legal representatives and assigns.

____ _________________________

Participant Name Date

____

Parent/Legal Guardian (If Participant is a Minor)

HIPAA AUTHORIZATION FOR DISCLOSURE OF PHI

I, __________________________________, hereby consent and authorize ARCH PHYSICAL THERAPY & SPORTS MEDICINE and its employees, agents, partners, and affiliates (collectively "Clinic") to disclose my Protected Health Information ("PHI"), as that term is defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for marketing purposes, as stated below. I understand that subsequent disclosures by recipients of my PHI may not be protected by the HIPAA Privacy Rule or other applicable medical record privacy laws.

Further, I authorize Clinic to disclose my PHI, in the form of written statements, photographs, and videotape/audiotape recordings, for purposes of promoting and advertising Clinic's services.

I understand that I may revoke this authorization at any time by giving written notice to Clinic, except to the extent that Clinic and its agents, employees, and representatives may have taken action in reliance on this authorization.

This authorization is effective on the date stated below for an indefinite period of time. A photocopy of this authorization form is valid and should be given the same force and effect as the original.

____ _____________________

Participant Name Date

____

Parent/Legal Guardian (If Participant is a Minor)

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)			