Northern Arizona
REHABILITATION AND FITNESS

Name: _____ Date: _____ DOB: _____ Height: _____ Weight: _____

Mailing Address: _____
(CITY) (STATE) (ZIP CODE)

Tobacco user: ☐ Yes ☐ No ☐ Former

Phone #: _____ E-mail: _____ Social Security Number: _____

Employer/Occupation: _____ Currently Working: _____

Emergency Contact: _____ Phone #: _____

Do you have: pacemaker? ☐ Yes ☐ No Internal stimulator (brain/spinal)? ☐ Yes ☐ No Is this injury work related? ☐ Yes ☐ No

Chief Complaint: _____ When did present symptoms start: _____ Cause: _____

What medical help have you sought for current problem? ☐ Doctor ☐ Chiropractor ☐ Physical Therapy ☐ Occupational Therapy

Are you currently receiving Home Health Services? [] Yes [] No If yes, explain _____

Have you had any x-rays or MRI to diagnose current problem? ☐ Yes ☐ No If yes, when & results? _____

Have you had other tests performed regarding above problem? _____

Have you had any loss of sensation with current problem? _____

Can you get comfortable at night? _____

Have you had a similar problem before? ☐ Yes ☐ No If yes, how long ago? _____

Have you ever had physical or occupational therapy for this similar problem? ☐ Yes ☐ No If yes, what type of treatment did you receive?

_____

Do you have pain related to your current problem? ☐ Yes ☐ No

Where is the pain? (mark diagram to the right using the "key")

Has the pain spread? ☐ Yes ☐ No if yes, where? _____

_____

Describe your pain/symptoms: (check if applicable)

☐ stays all the time ☐ throbbing ☐ dull ☐ burning ☐ shooting

☐ comes and goes ☐ numbness ☐ sharp ☐ tingling ☐ pricking

☐ pressure ☐ aching ☐ heavy ☐ gnawing

What activities/positions increase your pain? _____

_____

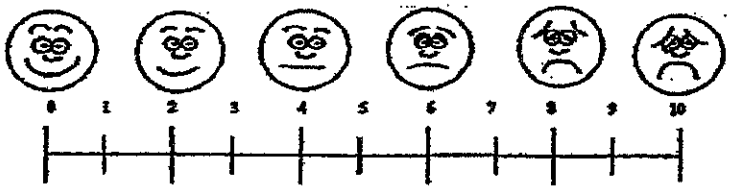
What activities/positions decrease your pain? _____

_____

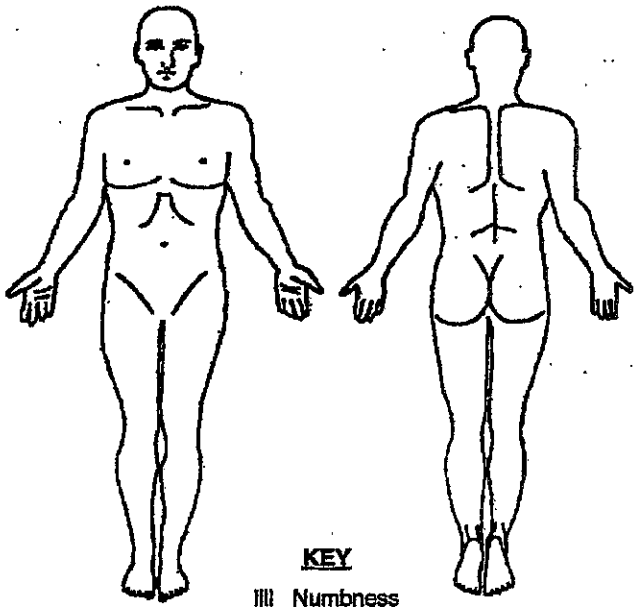
What activities does pain interfere with or prevent you from doing? _____

_____

Please rate your pain/comfort level using scale below: _____



What is your goal for pain relief using above scale? _____



KEY
IIII Numbness
00 Pain
XX Tingling

Are you open to your PT going with you to your physician follow-up visits? ☐ Yes ☐ No

Northern Arizona Rehabilitation & Fitness / MEDICAL HISTORY FORM

LIST SURGERIES, FRACTURES & INJURIES	LIST MEDICATIONS

*****CHECK ALL THAT APPLY BELOW IN THE BOX PROVIDED TO THE RIGHT OF THE CONDITION*****

MUSCULOSKELETAL:

Osteoarthritis		MI/Heart Attack	
Osteopenia/Osteoporosis		Angina	
Rheumatoid Arthritis		Congestive Heart Failure	
Spinal Compression Fracture		High Blood Pressure	
Meniscus Tear/Knee(s)		High Cholesterol	
Disc Herniation Neck/back		Arrhythmia	
Whiplash		Blood Clot	
Spinal DDD/DJD/Stenosis		Aneurysm	
Shoulder Dislocation		Shortness of Breath	
Prosthesis/Joint Replacement		Asthma	
Lupus		Emphysema/COPD	
Gout		Peripheral Vascular Disease	
Other:		Tobacco User:	

CARDIOPULMONARY:

NEUROMUSCULAR/NEUROLOGICAL:

Frequent Falls		Cancer	
Stroke/CVA		Internal Organ Dysfunction	
Epilepsy/Seizures		Hepatitis	
Peripheral Neuropathy		Clinical Depression	
Carpal Tunnel Syndrome		Anxiety/Panic Disorder	
Brain Injury/Head Injury		Visual Impairment	
Parkinsons		Hearing Impairment	
Neurological Disorder (MS or other)		Urinary Incontinence	
Other:		Gastrointestinal Problems	
		Allergies	

INTEGUMENTARY/OTHER:

Are you or might you be pregnant? ◊ yes ◊ no Marital Status ___M___S___D___W____

What are we treating you for? _____

What are your physical therapy goals? _____

Current Stress Level: ◊ None ◊ Moderate ◊ High

Signature: _____ Date: _____

Northern Arizona Rehabilitation & Fitness Cancellation and No Show Appointment Policy

The following are our policies regarding cancellations and no-shows. We take this subject seriously at the clinic, because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and/or your therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your therapist's instructions and we will be able to help you achieve your goals in treatment.

- We require **24 hours** notice in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible. (In some cases, this may not work since some forms of treatment do not work well if given two sequential days.)
- There will be a **$25.00** charge for appointment cancellation without 24 hour notice. This charge will not be covered by insurance, but will have to be paid by you personally.
- For **Worker's Compensation** and **AHCCCS** patients, documentation of any missed appointments must be forwarded to your Case Manager and Primary Physician which could jeopardize your claim.
- You may need to see a therapist other than the one who normally treats you if you re-arrange your appointment. All of our therapists are experienced professionals, and they study your patient chart, so you will be in good hands.
- Please understand that your pain may increase and decrease as your course of treatment progresses and before it is finally erased. Either condition can seem to be a reason not to come in: **a) you're feeling worse and think the treatment is not working or, b) you're feeling better and it's a great day for hiking. Neither of these conditions is legitimate as a reason not to come. If you're in pain, come in and get it fixed.** If you're out of pain, now is the time that we can begin doing some real correction of the underlying causes of your problem, educate you so you won't re-injure yourself, etc.

When you do not show as scheduled, three people are affected: <u>you</u> because you don't get the treatment you need as prescribed by the doctor and /or PT; <u>the therapist</u> who now has a space in their schedule since the time was reserved for you personally; and <u>another patient</u> who could have been scheduled for treatment if there had been proper notice.

If you do not show for 2 consecutive appointments or three appointments during the course of your therapy or if you fail to return repeated telephone calls from our staff; your referring physician and case manager will be notified. All remaining appointments will subsequently be removed from your schedule.

Please co-operate with us in this regard. We're looking forward to working with you.

I have reviewed this policy with a member of NARF staff. I understand and agree to abide by this policy.

_____ _____

Patient Signature **Date**

_____ _____

NARF Staff Signature **Date**

Northern Arizona Rehabilitation & Fitness, PC
Financial Policy

FOR ALL PATIENTS: Please be assured that your health is our primary concern. The following office policies are outlined for your benefit in order to avoid possible areas of confusion. The office personnel are available to assist you if you have any questions.

Northern Arizona Rehabilitation & Fitness, PC accepts assignment for Medicare. If your insurance plan has a co-payment, co-insurance or a deductible that has not been fulfilled, the payment of the co-payment, co-insurance and/or the amount of the remaining deductible is due at the time of service.

As a courtesy to you, this office will bill your insurance. We will also bill your Medicare secondary insurance if applicable. However, any and all charges not covered by your insurance(s) are due and payable without delay, unless prior arrangements are made with this office.

Our office will also verify the presence of insurance coverage on your primary insurance; however, you are responsible for knowing the benefits and restrictions of your insurance policy. At your request, we will assist you with obtaining pre-certification or pre-authorization required by your insurance.

Any special requirements for services, pre-certification for services, or pre-authorization are ultimately your responsibility.

****

I have read and understand the above Financial Policy and hereby acknowledge that any and all medical bills, collection fees on my account, or lawyer's fees incurred due to my delinquent payments are my personal responsibility.

I hereby authorize Northern Arizona Rehabilitation & Fitness to perform rehabilitation services to myself/child and authorize them to release my therapy records (including my evaluations, treatment records and progress notes to my physician, insurance carrier, and/or other named institutions).

I authorize payments of medical benefits to Northern Arizona Rehabilitation & Fitness for any medical care rendered to myself or to my dependents. I understand that I am responsible for any amount not covered by my insurance.

I acknowledge all of my patient information is complete and true. I also understand that overdue balances may incur additional charges. I will bear the cost of collection and/or court costs/legal fees should this be required.

Signature: _____ Date: _____

Witness: _____ Date: _____

****

Emergency Contact Information

Name: _____ Telephone: _____

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Northern Arizona Rehabilitation & Fitness, PC
Patient Information Consent Form

I have read and fully understand Northern Arizona Rehabilitation & Fitness' Notice of Information Practices. I understand that Northern Arizona Rehabilitation & Fitness may use or disclose my personal information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrated operations related to treatment or payment.

I also understand 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 Northern Arizona Rehabilitation & Fitness will consider requests for restriction on a case by case basis, but does not have to agree to request for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Northern Arizona Rehabilitation & Fitness' Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____
Patient Name

_____
Signature

_____
Date

HIPAA NOTICE OF PRIVACY PRACTICES FOR PERSONAL HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members. **Payment.** Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated. **Health care operations.** Your health information may be used as necessary to support the day-to-day activities and management of Northern Arizona Rehabilitation & Fitness. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality .**Law enforcement.** Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting .**Public health reporting.** Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department. **Appointment reminders.** Your health information may be used by our staff to send you appointment reminders .**Information about treatments.** Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

Individual Rights: • the right to request restrictions on the use and disclosure of your protected health information• the right to receive confidential communications concerning your medical condition and treatment• the right to inspect and copy your protected health information• the right to amend or submit corrections to your protected health information• the right to receive an accounting of how and to whom your protected health information has been disclosed• the right to receive a printed copy of this notice

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Office Manager.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Office Manager
Northern Arizona Rehabilitation & Fitness
480 S. Willard Street
Cottonwood, AZ 86326