BALANCED

PHYSICAL THERAPY | PILATES & PERFORMANCE CENTER

Last Name _____ First_____ MI ____

DOB _____ Sex _____ Marital Status _____

Home Address _____

City _____, State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____
Emergency Contact & Relationship _____
Phone _____
Employer Name _____ Work phone _____
Employer Address _____
City _____, State _____ Zip _____

Have you had physical therapy this year? _____ If so, where _____
How did you hear about us? _____

Referring Physician Name _____

Primary Physician Name _____

PRIMARY INSURANCE INFORMATION
Insurance Carrier _____
Policy Number _____Group Number _____
Address _____ City _____ State ____Zip _____
Policy Holder _____ Sex _____ DOB _____
Phone Number _____ Relationship _____
Policy Holder Employer Name and Address _____
_____ Phone _____

SECONDARY INSURANCE INFORMATION
Insurance Carrier _____
Policy Number _____Group Number _____
Address _____ City _____ State ____Zip _____
Policy Holder _____ Sex _____ DOB _____
Phone Number _____ Relationship _____
Policy Holder Employer Name and Address _____
_____ Phone _____

WORKERS COMPENSATION INFORMATION

Are you being seen for physical therapy due to a work related injury? _____
Date of Injury _____
Employer Name _____
Employer Address _____
City _____, State _____ Zip _____

Supervisor Name _____ Phone _____
Workers Comp Insurance Carrier _____
Contact Name _____ Phone _____
Address _____ City _____ State ____Zip _____

Designated Individuals Authorization

I hereby authorize the following parties to request and receive the release of 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:
Spouse _____
Name _____ **Relationship** _____
Name _____ **Relationship** _____

_____ _____
Patient / Legal Guardian Signature **Date**

Release of Information and Assignment of Benefits

I hereby give my permission to Balanced Physical Therapy, Inc. to release information to my insurance company, attorney, assignees, and/or beneficiaries. I authorize payment directly to Balanced Physical Therapy, Inc. for services rendered. In consideration of the services rendered and to be rendered to the above patient by Balanced Physical Therapy, Inc., I expressly guarantee payment of this account and agree to pay any charges left unpaid in whole or in part by the insurance company. **The patient is ultimately responsible for account totals and balances**. I understand that I will be responsible for any attorney fees, collections fees, and/or legal fees in the collection of unpaid accounts.

Please be aware that we require payment for all co-pays, deductibles, and coinsurances that your insurance will not pay at the time of service. Also, be aware that all supplies used for home use (stretch straps, ice packs, etc) must be paid by the patient. Although most insurance companies will not cover these items, you may submit a receipt to your insurance company for reimbursement if available.

Thank you for the opportunity to provide your physical therapy needs. You are very important to us and we welcome any questions and concerns regarding your financial responsibility. Please sign and date at the bottom.

_____ _____
Patient / Legal Guardian Signature **Date**

20325 N. 51st Ave, Bldg 6, Ste. 148, Glendale, AZ 85308
Phone 623.249.3216 Fax 623.249.3218

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PHYSICAL THERAPY | PILATES & PERFORMANCE CENTER

CLINIC POLICIES

Balanced Physical Therapy strives to provide the best personalized care possible. In order to make this possible, we have implemented the following clinic policies. Please read each policy carefully and acknowledge your agreement by initialing next to each patient policy and signing at the bottom.

___ To ensure you receive the maximum benefit from each therapy session, please be on time to your appointment. If you are more than 15 minutes late it may be necessary to reschedule your appointment, in which case the Clinic may charge you a $75 missed appointment fee.

___ As a courtesy to our patients, we require a 24 hour notice if you need to reschedule or cancel your appointment. If you cancel or reschedule your appointment on less than 24 hours notice, the Clinic may charge a $75 missed appointment fee.

___ We may attempt to verify your insurance benefits as a courtesy to you. However we strongly encourage you to know your benefits for physical therapy as well. Please be aware that you are ultimately responsible for payment.

___ It is your responsibility to be compliant with your physical therapy appointments and progress to meet your goals. If you are being seen for a workers compensation injury, we are required to communicate missed or cancelled appointments to your case manager and/or insurance company.

I have read, agree and understand the above clinic policies. In the event that the policies are broken, I agree to the charges/fees implemented as stated above.

_____ _____

Patient / Legal Guardian Signature **Date**

Balanced Physical Therapy
20325 N. 51st Ave, Bldg 6, Ste. 148, Glendale, AZ 85308
Phone 623.249.3216 Fax 623.249.3218

RELEASE AND WAIVER AGREEMENT

I, _____ voluntarily desire to participate in Physical Therapy and exercise conducted at Balanced Physical Therapy located at 20325 N. 51st Ave, Bldg 6 Ste 148, Glendale, AZ 85308.

I understand and agree to the following:

1. I understand that it is my responsibility to consult with a physician before beginning any exercise program.
2. I am aware that there exists the possibility of certain conditions occurring during or following training and/or exercise. These include, but are not limited to: mild light headaches, fainting, abnormalities of blood pressure and/or heart rate, injuries to bones, joints and muscles, neck or spinal injuries, ineffective heart function, and in rare but serious instances, heart attack, stroke, or death.
3. I understand that I am voluntarily participating in these activities and understand that I may, at any time, choose not to participate in a particular activity.
4. I understand that I may not use any Clinic equipment or participate in any Clinic activity outside the course of my physical therapy treatment without discussion with the physical therapist.
5. I agree and have been informed that exercise involves possible risks and all exercises are undertaken at my sole risk and that neither Balanced Physical Therapy, nor its directors, employees or agents shall be liable to me or any other person, for any claims, demands, actions or causes of action for injuries or other damages, whatsoever, to my person or property arising out of or connected with my use of Clinic services, facilities, equipment or my participation in Clinic activities, classes or programs. I do hereby release and discharge Balanced Physical Therapy thereof from all such claims, demands, actions or causes of action for such injuries or damages sustained by me

I HAVE READ THE ABOVE STATEMENTS AND UNDERSTAND THE CONDITIONS.

_____ _____

Patient/Client Signature **Date**

_____ _____

Guardian/Parent Signature (if under 18 y/o) **Date**

_____ _____

Witness **Date**

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MEDICAL HISTORY QUESTIONNAIRE

Please fill out this form as complete as possible. This information will assist your Physical Therapist in developing a plan of care for you to meet your goals.

Name: _____ DOB: _____ Age: _____ Height: _____ Weight: _____
Date of Injury: _____ Work related? _____ Date of Surgery: _____
Occupation: _____ Work Status: _____

Reason for this visit:
Where is your problem area(s): _____
Current symptom level: (1 through 10; (10 = pain/symptoms that takes you to the emergency room/worse pain imaginable):
In AM: _____ / 10 My symptoms feel like: _____
Thru/o Day: _____ / 10 My symptoms feel like: _____
In PM: _____ / 10 My symptoms feel like: _____
Sleeping: _____ / 10 My symptoms feel like: _____
My symptoms are worse with: _____
My symptoms are better when: _____
YOUR Goals: _____

Previous physical therapy for: _____ When: _____

Previous Surgeries (ALL) and when:
_____
Recent X-ray/MRI/CT Scans, when and result if known: _____
_____
Current Medications: (list medication and for what condition)
_____
_____

Known Allergies: No Yes: _____

Please check all the conditions that apply to you either in the present or the past:

___High Blood Pressure
___Low Blood Pressure
___Chest Pain / Angina
___Heart Attack
___Stroke
___TIAs
___Heart Disease
___Heart Surgery
___Diabetes Type I
___Diabetes Type II
___Hypoglycemia
___ Bronchitis
___COPD / Emphysema
___Asthma – seasonal
___Asthma - exercise induced
___Headaches
___Epilepsy
___Loss of Bowel
___Loss of Bladder
___Kidney Disease
___Dialysis
___Urinary Tract Infection
___Gall Bladder / Appendix
___Hepatitis
___Tuberculosis
___ Loss of Vision / Visual Disturbances
___Difficulty Swallowing
___Dizziness
___Hearing Loss
___Cancer Type: _____
Result: _____
___Ulcers
___Thyroid Problems: ___ HYPER ___ HYPO
___Depression
___ Chemical Dependency (Alcohol / Drugs)
___ Smoker
___ Psychological / Emotional Problems
___ PTSD
___Osteoarthritis
___Rheumatoid Arthritis
___Gout
___Ehlers–Danlos syndrome
___Scoliosis
___Osteoporosis
___Osteopenia
___ Pregnant
___ OTHER: _____
_____

If you marked any of the above, please give a brief explanation:

_____
_____
_____
_____

How many packs of cigarettes do you smoke per day? _____ up or down from _____

How many times during the week do you drink alcohol? _____ up or down from _____

Any other substances do you regularly use? _____

GENERAL HEALTH

Do you exercise regularly? _____ If so, what/when _____

_____

Do you have difficulty sleeping? No Yes, why do you think: _____

Are you on a special diet prescribed by your physician? No Yes, what: _____

Have you had any unexplained weight loss in the past 3 months? No Yes: _____

Have you noticed any lumps or thickening of muscle or skin on your body? No Yes: _____

Any current activity and/or work restrictions from your physician? No Yes: _____

_____

Any current activities that you have trouble completing? _____

_____
_____

WORK ENVIRONMENT

In general, what activities do you do at work (please check):

___ Prolonged sitting (___ hrs) ___ Prolonged standing (___ hours)
___ Prolonged walking (___ hrs) ___ Prolonged bending and twisting (___ hours)
___ Use of large equipment ___ Use of small equipment
___ Please circle all that apply to your work environment: Lifting (____ to ____ lbs), bending, twisting, climbing, turning, reaching, pulling, pushing, other: _____
___ I use supports, cushions or braces: No Yes: _____
Any current activity and/or work restrictions from your physician? No Yes: _____

_____

When is your next referring physician appointment? _____

_____ _____
Patient Signature Date

_____ _____
Physical Therapist Signature Date

PT COMMENTS:

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STATEMENT OF PRIVACY NOTICE

BALANCED PHYSICAL THERAPY LEGAL DUTY

NOTICE OF PRIVACY PRACTICES

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.

We are required by law to:

- make sure that your health information is kept private;
- give you this notice of our legal duties and privacy practices; and
- follow the terms of the notice that is currently in effect.

We understand that your health information is personal. We create a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. We are committed to protecting this information.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

We may use or share your health information in certain ways. We will explain how and when we may use or share your health information. We are not able to list each specific way we may use or share your health information, but each situation will fall into one of the basic types of situations below:

- **For Treatment**. It is important that we be able to use or share your information to treat you. We may share your information to doctors, PT students, or other personnel who are involved in taking care of you.

- **For Payment**: We may use or share your health information so that we are paid for the cost of your care. We may bill, and share information with other providers, an insurance company, you, or a third party.

- **Appointment Reminders**. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care within the health system. If you do not wish to receive appointment reminders, or wish to be contacted at a certain telephone number, be sure to let us know.

- **Health-Related Benefits and Services**. We may use and disclose medical information to tell you about treatment options, health-related benefits, or services that may be of interest to you.

- **Individuals Involved in Your Care or Payment for Your Care**. We may release medical information about you to a family member or other designated person who is involved in your medical care. We may also give information to someone who helps pay for your care.

SPECIAL SITUATIONS: Additional uses and disclosures for which authorization or opportunity to agree or object is not required by HIPAA.

- **As Required By Law**. We will disclose medical information about you when required to do so by federal, state or local law.

- **To Avert a Serious Threat to Health or Safety**. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

- **Workers' Compensation**. We may release medical information to Workers' Compensation, as required by workers' compensation laws. This program provides benefits for work-related injuries or illness.

- **Public Health Risks**. As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury, or disability; reporting medical device safety issues and adverse events to the federal Food and Drug Administration's MedWatch program; and reporting disease or infection exposure.

- **Victims of Abuse, Neglect, or Domestic Violence.** We may disclose certain health information to government agencies authorized by law to receive reports of abuse, neglect, or domestic violence if we believe that you have been a victim.

- **Health Oversight Activities**. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure.

- **Judicial and Administrative Proceedings.** We may disclose your health information in the course of an administrative or judicial proceeding, such as in response to a court order

- **Law Enforcement**. We may release medical information to a law enforcement official if required or permitted by law.

- **Deceased Person Information.** We may release medical information to a coroner or medical examiner, or a funeral director as necessary to carry out their duties.

- **Specialized Government Functions** We may release medical information about you to authorized federal officials for national security and intelligence, military, or veterans activities required by law.

USES OF MEDICAL INFORMATION THAT REQUIRE AUTHORIZATION

In all other situations (situations that are not treatment, payment, health systems operations or special situations, as we told you about above), we may only share information with your specific written authorization. You may revoke that authorization, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization, except to the extent that we already have used or disclosed your information.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

Although the physical form of your medical information or designated record set is our business record and is the property of the health system, the information contained in those records is your information, and you have certain rights regarding that information.

You have the following rights regarding medical information we maintain about you:

- **Right to Review and Copy**. You have the right to inspect and obtain a copy of medical information that may be used to make decisions about your care. You must submit your request for your medical information in writing to the office manager of the office where you received your care. If you request a copy of the information, we may charge a fee for the costs of copying and mailing.

- **Right To Appeal a Denial of Access to Medical Information.** You have the right to access your medical information. There are some limitations on that right. If for clear treatment reasons your health provider has determined that access to your health information is likely to have an adverse effect on you, the health care provider shall provide the record to a practitioner designated by you to help you with your review of the information.

- **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is maintained. We may deny your request if you ask us to amend information that is not part of the information which you would be permitted to inspect and copy; or we believe is accurate and complete.

- **Right to an Accounting of Disclosures**. You have the right to request an accounting of disclosures of your protected health information made by us.

- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. **We are not required to agree to your request.**

- **Right to Request Confidential Communications**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

- **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this notice at any time upon request.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. Current copies of this notice will be available at our office.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our health system by either contacting the Privacy Officer by calling this office at 623.249.3216; or to HIPAA Customer Service. All complaints must be submitted in writing to:

Balanced Physical Therapy (20325 N. 51st Ave Bldg 6, Ste 148 Glendale, AZ 85308) to the attention of: Privacy Officer.

You will not be penalized for filing a complaint.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

Acknowledgement of Notice of Privacy Practices

"I hereby acknowledge that I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES**. I understand that if I have questions or complaints regarding my privacy rights that I may contact the office. I further understand that the practice will offer me updates to this **NOTICE OF PRIVACY PRACTICE** should it be amended, modified, or changed in any way."

_____

Patient or Representative Name (please print)

_____

Patient or Representative Signature Date

☐ Patient refused to sign ☐ Patient was unable to sign because _____

Authorized Facility Signature _____ Date _____

Effective 8.01.2007

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CREDIT CARD INFORMATION

At Balanced Physical Therapy we give the highest 1 on 1 quality patient care. Each patient is scheduled for 1 hour with one of our Physical Therapists. It is important that you follow our Cancellation Policy as our therapists have booked that time for you.

Having the 24 hour notice gives us the opportunity to fill the vacant spot with another patient who is on the waiting list. Because of this, it is our policy to have a credit card on file for each patient. Your card will only be billed if you no show for your scheduled appointment, or you do not cancel within 24 hours. We do understand that emergencies come up, and adjustments will be made accordingly. Below please find our cancellation policy.

Cancellation Policy: At Balanced Physical Therapy we have a 24 hour cancellation policy. Failure to give 24 hours notice or failure to arrive for a therapy session without notifying the office will result in a $75.00 fee.

Name: _____

Credit Card Type: _____ Card Number: _____

Expiration Date: _____ Billing Zip Code: _____

Signature: _____ Date: _____

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All PT sessions are 1-on-1 with a PT the entire session!

Please read thoroughly and initial. Your signature is required at the bottom. Thank you!

Top reasons NOT to cancel or "no-show" your scheduled appointments:

1) Consistent and timely implementation of treatments is the KEY TO RECOVERY.
   INITIALS _____

2) Prevents regression or the loss of gains acquired from previous sessions.
   INITIALS _____

3) Allows your clinician to assess your current symptoms (better or worse) more consistently for BEST outcome and results.
   INITAILS _____

4) Avoid unnecessary cancellation fee of $75. This fee is charged when appointments are cancelled less than 24 hrs of appointment time.
5) INITIALS _____

6) Unlike other physical therapy clinics, at Balanced your Physical Therapist's hour is dedicated to YOUR HOUR. If you are unable to re-schedule in a timely and effective manner, then your therapist will not be able to see another patient and will have NO ONE to see for that hour. It is a "wasted" hour for a very beneficial session for someone!
   INITIALS _____

7) Keep in mind, if you cancel frequently, we might have to make arrangements that work for both your schedule and the physical therapists schedule to both work effectively.
   INITIALS _____

   Patient Signature: _____ Date: _____

*Thank you for your **understanding and your commitment** to your physical therapy experience here at Balanced. We are happy to be meeting you and welcoming you into our family. You are very important to us!*

20325 N. 51st Avenue, Building 6, Suite 148, Glendale, AZ 85308
Phone:623.249.3216 Fax:623.249.3218