ONEACCORD PHYSICAL THERAPY

REGISTRATION FORM

(Please Print)

Today's date:				**Primary Doctor:**		
PATIENT INFORMATION						
Patient's last name:	**First:**	**Middle:**	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	**Marital status (circle one)** Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	**If not, what is your legal name?**	**Birth date:** / /	**Sex:** ❑ M ❑ F	**Age:**	**Email Address (IMPORTANT):**	
Street address:		**Social Security no.:**			**Home/Cell phone no.:** ( )	
P.O. box:	**City:**		**State:**	**ZIP Code:**		
Occupation:	**Employer:**			**Employer phone no.:** ( )		
Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Website ❑ Other ❑ Facebook						
Other family members seen here:						
Emergency Contact Person:		**Phone Number:**				
Primary Care Physician:		**Referring Physician:**				

Release of Information

I Authorize the release of medical information to the person(s) named below and do agree that any details regarding my condition or treatment may be disclosed.

Name:	**Relationship:**
Name:	**Relationship:**
Name:	**Relationship:**

I give OAPT permission to leave messages on my voice mail: ❑ Yes ❑ No

Assignment of Benefits to One Accord Pain Centers, PLLC

This is a direct assignment of my rights and benefits under this policy.

One Accord Pain Centers, PLLC
2500 S. Power Rd. Bldg 11 Suite 126-4
Mesa, AZ 85209

If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and One Accord Pain Centers and mail it to the above address for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

- **This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.**
- **A photocopy of this Assignment shall be considered as effective and valid as the original.**
- **I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment.**
- **I authorize the use of this signature on all insurance submissions.**
- **I authorize One Accord Pain Centers to deposit checks made in my name.**
- **I authorize One Accord Pain Centers to initiate a complaint to the Insurance Commissioner for any reason on my behalf.**
- **I understand that I am financially responsible for all charges whether or not paid by insurance.**
- **I have read and understand the OAPT Notice of Privacy Policy.**

Signature of Policyholder: _____ ***Date*** _____

Witness: _____ ***Date*** _____

CONSENT TO TREAT AND IMPORTANT POLICIES

I, _____ **consent and authorize OneAccord Physical Therapy to provide physical therapy services** that may be considered appropriate upon the professional judgment of my treating therapist, and/or my referring physician. I also understand that I have the right to ask, and have any questions answered prior to, during, and after treatments. This includes risks, benefits, alternatives, and purpose of treatments. I understand that under the supervision of my physical therapist, treatment may include; electrical stimulation, dry needling, spinal manipulation, ultrasound, laser treatment, joint mobilizations, therapeutic exercise, moist heat, cupping, traction, ice, paraffin, soft tissue mobilization, neuromuscular re-education, and the use of exercise equipment. I understand that my physical therapist will utilize such interventions, as he/she deems appropriate to my care.

IMPORTANT POLICIES:

- Late Policy – Being late by more than 10 minutes will require you to either reschedule, or wait for the next available opening. There are no guarantees since openings due to cancellations can be unpredictable.
- 24-Hour Advance Notice Fee- If you wish to change or cancel an appointment, we require a minimum of 24 hours advance notice. Anything less will result in a $35 fee charged to your account. It costs us money to make appointments available to you. Whether you attend or not, we will still accrue expenses,
- No Shows- If you fail to show for an appointment without notice, all future appointments may be removed and a $50 fee will be assessed to your account.

FINACNIAL POLICIES:

Insurance coverage is never guaranteed. Although our office does verify coverage, online services only provide limited information. While we try to obtain accurate insurance benefits we are occasionally given incorrect information. If this occurs, you are responsible for any difference in what your insurance company quoted and what was actually paid.

- ***I understand that my insurance company does not guarantee the information provided to One Accord Physical Therapy and that I will double-check my insurance benefits.***

- **Account Responsibility:** Many people are under the impression that if they have insurance, it is the insurance company that owes One Accord Physical Therapy for their services. This is not the case. **The insurance contract is between you and the insurance company**; our relationship to you is as a patient to whom we are providing service.
- **Our responsibility**:
  - To bill all claims to your insurance carrier(s) in a timely manner on your behalf.
  - To assist you in resolving any problems with your claim payment.
- **Your responsibility:**
  - To provide us with current and accurate information to submit your claims correctly
  - To make certain if a current prescription from you doctor is needed for insurance purposes that you will obtain one, otherwise your claim could be denied.
  - To pay your co-pays, coinsurance or deductible payments at the time of service
  - To pay any additional amount owed as determined by your insurance carrier within 30 days of receipt of your first statement from us.
- Unpaid accounts past 90 days may be sent to a third party collection agency, and may have an additional 1.5% interest charge attached. Additional collection fees and/or attorney fees will be your responsibility. A $25 processing fee will be added to all returned checks.

We look forward to building a successful relationship with you that lasts a lifetime!

*Patient Name:*_____

Patient/Guardian Signature: _____ *Date*_____

NAME:_____ Date:_____

What is your gender? ❑ Male ❑ Female	Occupation:
Have you had physical therapy before? ❑ Yes ❑ No	Height: Weight:
What caused your pain/problem?	
When did it start:	
Is it getting worse, better, or staying the same?	❑ Worse ❑ Better ❑ The Same
Have you ever had this problem before?	❑ Yes ❑ No How often:
Is your pain constant?	❑ Yes ❑ No
What gives you relief?	
Have you fallen any time in the last year?	❑ Yes ❑ No

Medications:

Drug: _____ Dosage: _____ Reason for Taking:_____
Drug: _____ Dosage: _____ Reason for Taking:_____
Drug: _____ Dosage: _____ Reason for Taking:_____
Drug: _____ Dosage: _____ Reason for Taking:_____

Surgical History

Body Region: _____ Surgery Type: _____Date of Surgery:_____
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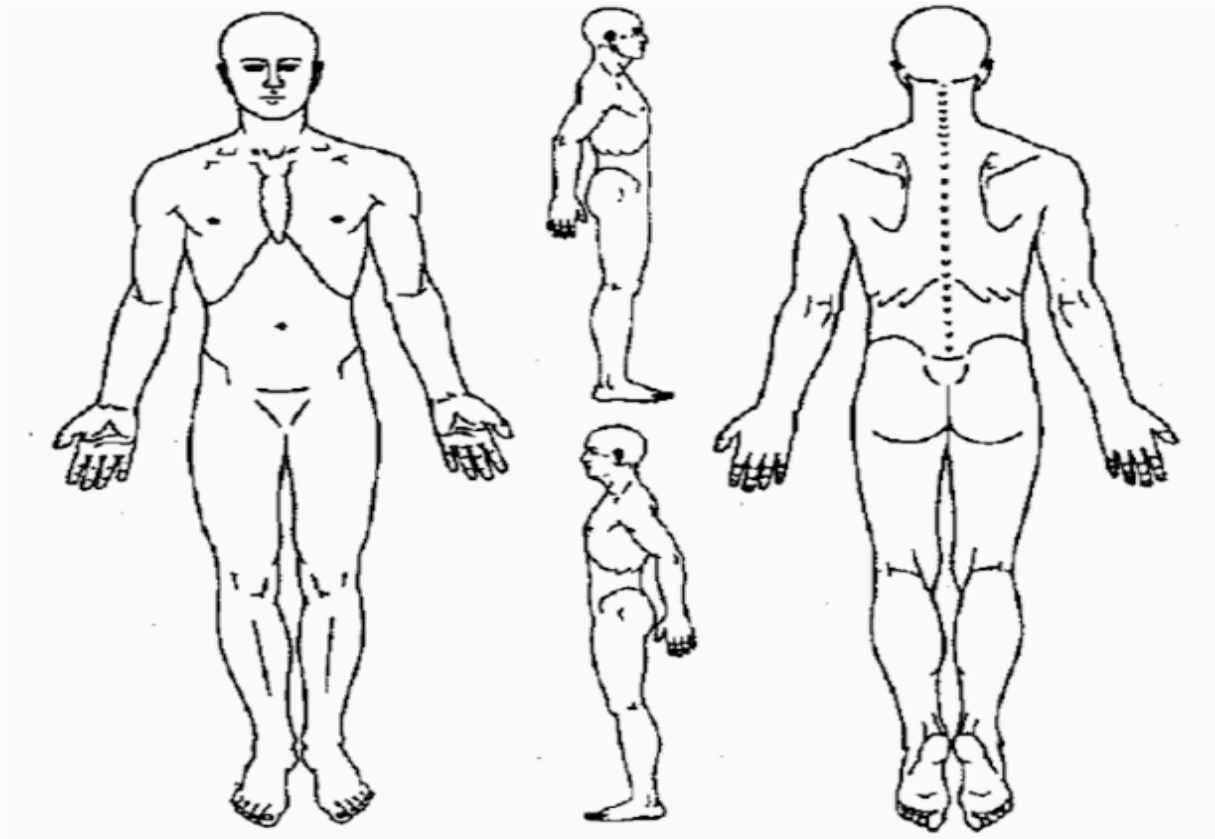
Past Medical History, do you have any of the following? (Please Check)

❑ Allergies	❑ Circulation Problems	❑ Hearing Impairment	❑ Muscular Disease
❑ Anemia	❑ Currently Pregnant	❑ Hepatitis	❑ Osteoporosis
❑ Anxiety	❑ Depression	❑ High Cholesterol	❑ Parkinsons
❑ Arthritis	❑ Diabetes	❑ High/Low Blood Pressure	❑ Rheumatoid Arthritis
❑ Asthma	❑ Dizzy Spells	❑ HIV/AIDS	❑ Seizures
❑ Autoimmune Disorder	❑ Emphysema	❑ Incontinence	❑ Smoking
❑ Cancer	❑ Fibromyalgia	❑ Kidney Problems	❑ Speech Problems
❑ Cardiac Conditions	❑ Fractures	❑ Metal Implants	❑ Strokes
❑ Cardiac Pacemaker	❑ Gallbladder Problems	❑ MRSA	❑ Thyroid Disease
❑ Chemical Dependency	❑ Headaches	❑ Multiple Sclerosis	❑ Tuberculosis
			❑ Vision Problems
			❑ Other (Please Specify)

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗



<u>Patient Specific Functional Scale:</u> Identify 3 to 4 important activities that you are unable to do or are having moderate to extreme difficulty doing. For each activity, rate the level of difficulty you have performing each activity using the 0-10 scale listed below. The higher the number, the more easily you can perform the activity. The lower the number, the more difficulty you have.

Rating Scale

Unable to perform the activity — Able to perform the activity at the same level as before pain.

0 1 2 3 4 5 6 7 8 9 10

Activity: Rating today:

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain.

Using the following scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

0–not at all 1–to a slight degree 2–to a moderate degree 3–to a great degree 4–all the time

When I'm in pain …

SCORE 0-4:

1. I worry all the time about whether the pain will end. _____
2. I feel I can't go on. _____
3. It's terrible and I think it's never going to get any better. _____
4. It's awful and I feel that it overwhelms me. _____
5. I feel I can't stand it anymore. _____
6. I become afraid that the pain will get worse. _____
7. I keep thinking of other painful events. _____
8. I anxiously want the pain to go away. _____
9. I can't seem to keep it out of my mind. _____
10. I keep thinking about how much it hurts. _____
11. I keep thinking about how badly I want the pain to stop. _____
12. There's nothing I can do to reduce the intensity of the pain. _____
13. I wonder whether something serious may happen _____

Total: _____

(FABQ) Waddell et al (1993) Pain, 52 (1993) 157 - 168

Here are some of the things which other patients have told us about their pain. For each statement please circle any number from 0 to 6 to say how much physical activities such as bending, lifting, walking or driving affect or would affect your back pain.

Circle your best answer:
Completely disagree =0 Unsure (2,3,4,5) Completely agree =6

1. My pain was caused by physical activity 0 1 2 3 4 5 6

2. Physical activity makes my pain worse 0 1 2 3 4 5 6

3. Physical activity might harm my back 0 1 2 3 4 5 6

4. I should not do physical activities which (might) make my pain worse 0 1 2 3 4 5 6

5. I cannot do physical activities which (might) make my pain worse 0 1 2 3 4 5 6

The following statements are about how your normal work affects or would affect your back pain
Completely disagree Unsure Completely agree

6. My pain was caused by my work or by an accident at work 0 1 2 3 4 5 6

7. My work aggravated my pain 0 1 2 3 4 5 6

8. I have a claim for compensation for my pain 0 1 2 3 4 5 6

9. My work is too heavy for me 0 1 2 3 4 5 6

10. My work makes or would make my pain worse 0 1 2 3 4 5 6

11. My work might harm my back 0 1 2 3 4 5 6

12. I should not do my normal work with my present pain 0 1 2 3 4 5 6

13. I cannot do my normal work with my present pain 0 1 2 3 4 5 6

14. I cannot do my normal work till my pain is treated 0 1 2 3 4 5 6

15. I do not think that I will be back to my normal work within 3 months. 0 1 2 3 4 5 6

16. I do not think that I will ever be able to go back to that work 0 1 2 3 4 5 6

FOR THERAPIST:
Scoring Scale 1: Work – items 6, 7, 9, 10, 11, 12, 15. Scale 2: Physical Activity – items 2, 3, 4, 5.

Source: Gordon Waddell, Mary Newton, Iain Henderson, Douglas Somerville and Chris J. Main, A (FABQ) and the role of fear-avoidance beliefs in chronic low back pain and disability, Pain, 52 (1993) 157 – 168,