

**ONEACCORD PHYSICAL THERAPY CASA GRANDE, GILBERT & PHOENIX, AZ
REGISTRATION FORM**

Today's date:			Primary Doctor:			
PATIENT INFORMATION						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	Birth date: / /	Sex: <input type="checkbox"/> M <input type="checkbox"/> 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):						<input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital
<input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Close to home/work <input type="checkbox"/> Website <input type="checkbox"/> Other <input type="checkbox"/> 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 Harvest Physical Therapy DBA One Accord Physical Therapy
This is a direct assignment of my rights and benefits under this policy.**

Harvest Physical Therapy 1377 E. Florence Blvd. Ste. 151-L5 Casa Grande, AZ 85122

If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and Harvest Physical Therapy 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 Harvest Physical Therapy to deposit checks made in my name.
- I authorize Harvest Physical Therapy 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 One Accord 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. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

Notice of DBA, (Doing Business As) One Accord Physical Therapy is a DBA for Harvest Physical Therapy. As such many of our insurance contracts are listed under Harvest Physical Therapy. Please do not be confused if your EOB says Harvest Physical Therapy and not One Accord Physical Therapy, they are one in the same. Please feel free to ask for clarity if need be.

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.

FINANCIAL 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 your 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: _____

Body Region: _____ Surgery Type: _____ Date of Surgery: _____

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Body Region: _____ Surgery Type: _____ Date of Surgery: _____

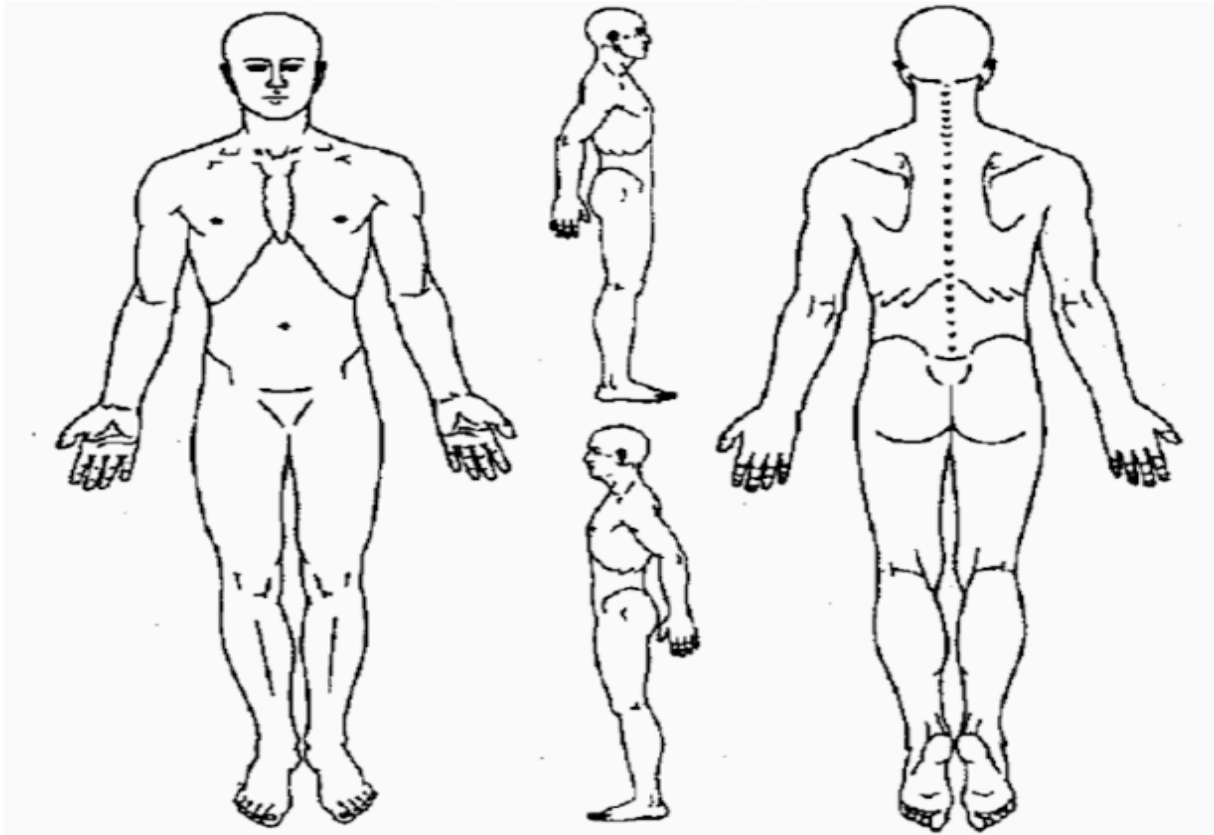
Past Medical History, do you have any of the following? (Please Check)

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Muscular Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Currently Pregnant | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Parkinsons |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dizzy Spells | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Autoimmune Disorder | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Cardiac Conditions | <input type="checkbox"/> Fractures | <input type="checkbox"/> Metal Implants | <input type="checkbox"/> Strokes |
| <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> Gallbladder Problems | <input type="checkbox"/> MRSA | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Headaches | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis |
| | | | <input type="checkbox"/> Vision Problems |
| | | | <input type="checkbox"/> 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
-----	○ ○ ○ ○ ○	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
-----	○ ○ ○ ○ ○	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
-----	○ ○ ○ ○ ○	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗



Patient Specific Functional Scale: 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. _____

- _____
- _____
- _____
- _____

NAME: _____

Date: _____

NAME: _____

Date: _____

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: _____

NAME: _____

Date: _____

(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,