



Date \_\_\_\_\_

**Patient Information**

Name \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_\_ Employer \_\_\_\_\_

Referring Physician \_\_\_\_\_

Is your condition/injury due to an accident? Auto \_\_\_\_\_ Work \_\_\_\_\_ Other \_\_\_\_\_

**If this is a work related injury:**

Date of Injury \_\_\_\_\_ Employer at time of Injury \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone # \_\_\_\_\_

Adjuster Name \_\_\_\_\_ Adjuster Phone # \_\_\_\_\_

Claim # \_\_\_\_\_

Patient Emergency Contact Information \_\_\_\_\_

Relationship \_\_\_\_\_ Phone # \_\_\_\_\_ Other Phone # \_\_\_\_\_

**Insurance Information (Primary)**

Insurance Company \_\_\_\_\_ Phone # \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insured (if not patient) SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ ID# \_\_\_\_\_

**Secondary Insurance Information (Medicare Patients Only)**

Insurance Company \_\_\_\_\_ Phone # \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insured (if not patient) SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ ID# \_\_\_\_\_



## **AUTHORIZATION FOR TREATMENT**

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Physical/Occupational Therapy is a patient care service provided in response to a wide range of medical care needs of outpatients of all ages, regardless of gender, color, national origin or disability, five days a week.

The purpose of Physical/Occupational Therapy is:

- To treat disease, injury and disability by evaluation, examination, testing and use of rehabilitative procedures, manipulations, massage, exercise, and physical agents including but not limited to mechanical devices, heat, cold, air, light, water, electricity and sound in the aid of diagnosis or treatment.
- To obtain for the physician, information needed in diagnosis and evaluation of patients.
- To prevent or minimize residual physical and mental disability.
- To aid the patient in achieving maximum potential within his/her capabilities.
- To accelerate convalescence and reduce the length of the functional recovery.

All procedures will be thoroughly explained to you before they are performed. There are certain inherent risks with pt/ot treatment because you will be asked to exert effort and perform activities with increasing degrees of difficulty, which could cause an increase in your current level of pain or discomfort or an aggravation to your existing injury. There is also a possibility that you could experience a new injury, but the risk is small. You will be able to control any procedure by stopping if you feel and increase in pain or discomfort.

The Physical/Occupational Therapist and or assistant will take every precaution to ensure that you are protected from any hazardous situation. You will never be forced to perform any procedure that you do not wish to perform.

Based on this information, I agree to cooperate fully and to participate in all Physical/Occupational Therapy procedures and to comply with the plan of care as it is established.

**NOTICE TO PATIENTS FOR PERSONAL SAFETY: DO NOT USE ANY EQUIPMENT WITHOUT A STAFF MEMBER PRESENT.**

Patient Name (printed) \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_



## PATIENT INFORMED CONSENT

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I have read and fully understand CATZ Physical Therapy Notice of Information Practices. I understand that CATZ Physical Therapy may utilize or disclose my health information in order to carry out treatment, to obtain payment, and to evaluate the care quality. I understand that I may request a restriction of the dissemination of my health information in the above cases, but CATZ Physical Therapy does not have to honor these requests legally.

I hereby consent to the use and disclosure of my health information for purposes as noted in the CATZ Physical Therapy Notice of Information Practices. I understand that I have the right to revoke this consent in writing at any time.

Patient Name (printed) \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

# HEALTH HISTORY

NAME \_\_\_\_\_ DOB \_\_\_\_\_ SEX MALE \_\_\_\_\_ FEMALE \_\_\_\_\_

PRIMARY CARE PHYSICIAN \_\_\_\_\_

CHIEF COMPLAINT \_\_\_\_\_ SIDE OF BODY \_\_\_\_\_ ONSET DATE \_\_\_\_\_

## DO YOU OR HAVE YOU EVER HAD

	Yes	No	Explain		Yes	No	Explain
Heart Trouble				Bad Teeth			
High blood pressure				Hearing Problems			
Stroke				Ulcer			
Blood Clots				Bladder Infections			
Anemia				Kidney Problems			
Bleeding Problems				Liver Problems			
Cancer				Hepatitis			
Asthma				Gout			
Emphysema				Thyroid Problems			
Tuberculosis				Seizures			
Diabetes				Psychiatric Care			
Glaucoma				Depression			
Arthritis				Prostate Problems			
Sleep Apnea				Other			

Allergies & Reactions: a) \_\_\_\_\_ b) \_\_\_\_\_ c) \_\_\_\_\_

Previous Operations & Dates: Please use the back for additional space

a) \_\_\_\_\_ d) \_\_\_\_\_  
 b) \_\_\_\_\_ e) \_\_\_\_\_  
 c) \_\_\_\_\_ f) \_\_\_\_\_

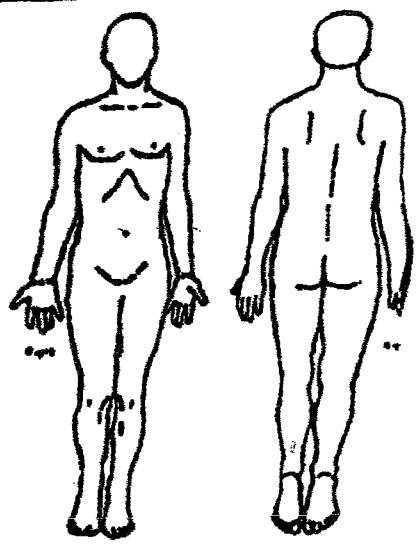
Medications: Please use the back for additional space

a) \_\_\_\_\_ d) \_\_\_\_\_  
 b) \_\_\_\_\_ e) \_\_\_\_\_  
 c) \_\_\_\_\_ f) \_\_\_\_\_

On the body diagram please mark where your pain is with an X  
 Pain Symptoms please rate your pain on an average day by marking a number  
 On the scale 0 (NO PAIN) \_\_\_\_\_ 10 (ER VISIT)

Have you received Physical or Occupational Therapy for this injury in  
 The past? Yes \_\_\_\_\_ No \_\_\_\_\_ if Yes list date \_\_\_\_\_

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_



# MEDICAL ASSIGNMENT OF BENEFITS AND FINANCIAL POLICY

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CATZ Physical Therapy is pleased to be a part of your rehabilitation experience. We believe that communication with our patients regarding our financial policy assists in providing the best service to you.

## **INSURANCE BILLING**

We will gladly call your insurance company to identify your coverage for your physical therapy services however, please understand that insurance companies will not guarantee this coverage. We can only use this information as a guideline. We strongly encourage you to contact your insurance company directly in order to understand your plans coverage and limitations. Please note that we will only bill your primary insurance carrier except for Medicare patients, when we will be a secondary carrier. Your insurance company may also require a current therapy prescription written by a physician, a letter of medical necessity and/or pre-authorization obtained by your doctor's office before physical therapy services can be provided. Non-compliance with any of these may result in services not reimbursed by your insurance company.

## **PAYMENTS**

All deductibles, co-pays, co-insurance and full cash payments are due at the time of services unless a written agreement has been made between the responsible party and CATZ Physical Therapy. Any insurance payments sent directly to the patient must be remitted to CATZ within 5(five) days of receipt. If a balance remains after all the payments have been processed, a final statement will be sent to you. Payment will be due, in full no later than 30(thirty) days from the date of the final statement. There will be a \$35.00 returned check fee and subsequent payments must be made in cash or credit card only.

If you have any questions regarding the above information, please contact a CATZ Physical Therapy staff member.

I, the patient (or legal guardian/responsible party for the patient), understand and agree that I am 100% responsible for all fees incurred at CATZ Physical Therapy. I agree to authorize CATZ Physical Therapy to release any medical information to insurance company, physicians, attorneys and to all pertinent parties that may be involved in my claim or care. I also agree to assign all payments of benefits to CATZ Physical Therapy.

Patient name (printed) \_\_\_\_\_

Signature of patient or responsible party \_\_\_\_\_

Date \_\_\_\_\_



**Physical Therapy**

# CONFIDENTIAL CHANNEL COMMUNICATION REQUEST

*As required by Health Information Portability and Accountability Act (HIPAA) OF 1996 you have a right to request that communications concerning your personal health information be made through confidential channels. This includes communicating with any Doctor's office and retrieving all records and reports related to your condition. This medical practice will not ask you why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided, and as appropriate, information as to how payment will be handled.*

I, \_\_\_\_\_ (print name) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. **This request supercedes any prior request for confidential channel communications I may have made.**

Please select all that apply. Where you list more than one communication option, please indicate which you prefer.

## Phone

I want you to contact me by telephone at: \_\_\_\_\_

\_\_\_\_\_ **Do** \_\_\_\_\_ **Do not** leave messages on my answering machine  
\_\_\_\_\_ **Do** \_\_\_\_\_ **Do not** leave messages with any other person

Please indicate name, if any, of individual(s) approved to take above messages:

\_\_\_\_\_

## Diagnosis & Treatment

I, \_\_\_\_\_ **Do** \_\_\_\_\_ **Do not** want you to discuss my diagnosis and treatment with my family members.

Please indicate name, if any, of individual(s) approved for diagnosis and treatment discussion(s):

\_\_\_\_\_

## Mail

I want you to contact me at the following address: \_\_\_\_\_

\_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print name: \_\_\_\_\_

If not signed by the patient, please indicate relationship:

- \_\_\_\_\_ Parent or guardian of minor patient  
\_\_\_\_\_ Guardian or conservator of an incompetent patient  
\_\_\_\_\_ Beneficiary or personal representative of deceased patient

Name of patient: \_\_\_\_\_



Physical Therapy

825 East Warner Road, Chandler, Arizona 85225  
480.722.0300 (office) 480.722.0302 (fax)

## **Cancellation/Rescheduling Policy**

Dear CATZ Physical Therapy Patients,

CATZ Physical Therapy seeks to provide the best patient experience available to all of our patients. We have an outstanding group of physical therapists who want your outcome to be the best possible. A positive outcome involves following your physicians and physical therapists plan of care.

Our physical therapists are also very accommodative of our patients scheduling needs. However, in an effort to most effectively schedule patients during the days and times of the day, we need your help. We request that you notify us 24 hours prior to cancelling an appointment. We also realize that a change in your schedule may occur in less than 24 hours. If that does occur, please call us and reschedule that days appointment within two(2) business days. If we do not receive a call 24 hours prior to an appointment or your appointment is not rescheduled within two(2) business days, we will bill your account \$25.00. Our desire is to maintain the same level of care that has made CATZ Physical Therapy in demand from our community and the medical providers which refer us patients.

We thank you for your support and understanding.

Sincerely,

**The CATZ Physical Therapy Team**

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Patient signature accepting terms of our policy

Date

**EFFECTIVE 09/22/2010**