Canyon View
PHYSICAL THERAPY

Patient Information:

First Name_____Last Name_____Preferred Name_____

DOB_____Address_____City, State, Zip_____

Phone_____Cell_____ Email_____

Text Message Reminders? YES or NO Cell Phone Provider_____

Referring Provider_____Seeking Therapy For_____

Employer_____ Employer Phone_____

Occupation_____Date of Injury?_____

Is your treatment caused by a Motor Vehicle Accident_____or Work Related?_____

Emergency Contact_____ Phone_____

If you are under the age of 18 Please fill out the following:

Parent/Guardian First Name_____Last Name_____

Relationship to Patient_____Date of Birth_____

Phone_____ Work Phone_____

Payor Information: (Please provide a copy of your Insurance/Payor information at check in)

Name of Payor_____ Policy #_____

Policy Holders Name_____DOB_____

Relationship to Patient_____Phone_____

Other Pertinent Information:

Are you receiving any Home Health Services of any kind at this time? Yes No **If yes, please notify receptionist.**

Have you had any Physical or Speech Therapy this year? Yes No If yes, how many? PT_____and/or ST_____

Have you had any Occupational Therapy this year? Yes No If yes, how many visits?_____

Financial Consent: I understand I am financially responsible for all charges incurred on my account unless I am under the age of 18. I consent Canyon View Physical Therapy (CVPT) billing my insurance and give permission to release information if requested by the payor. I understand in **most** cases the payor will submit payment to CVPT for services rendered. I also understand it is my responsibility to know my benefits and in some cases, insurance may not cover all or part of my services due to benefits being maxed out, deductibles, copays, etc. In the event my account is referred to a debt collector, I understand I will be responsible for all costs incurred to collect the debt in addition to my account balance.

Responsible Party Signature_____Date Signed_____

Patient First/Last Name_____**Date of Birth**_____

WELCOME TO CANYON VIEW PHYSICAL THERAPY

We genuinely appreciate your business. Our goal is to provide you with the highest quality of service and care available.

Attendance: Consistent attendance to your scheduled appointments is critical in your improvement.

Consent for Treatment: The undersigned hereby consents to physical therapy procedures that may be rendered, as ordered by my physician. I understand that my care is under the supervision of my attending physician, his or her assistants or designees, and that Canyon View Physical Therapy (CVPT) is not liable for any act or omission of treatment, when following the instructions of that physician.

No Show/Late Cancellation Fees: *Failure to provide* ***24-hour*** *notice of cancelling your scheduled appointment* ***or*** *Failure to Show for an appointment will result in a* ***$25.00*** *fee. This charge will be billed directly to* ***you****, not your insurance/payor. If you are scheduled for an Initial Evaluation and fail to show, you will be billed a* ***$50.00*** *fee. Fees must be paid prior to rescheduling. If you No Show/Late Cancellation more than 3 appointments during your course of treatment, we reserve the right to discontinue further treatment.* **Initials**_____

Work Related Injuries: If your treatment is due to a work-related injury, your therapy is an ongoing part of your responsibility to your employer. If you cancel, no show, or are chronically late for therapy, we may be required to contact your employer and/or physician. We do realize circumstances can change at the last minute. If you were unable to attend a scheduled appointment due to extenuating circumstances, please contact our Office Manager.

Release of Healthcare Information: I permit the healthcare organization or other health professionals involved in my care to release my healthcare information for purposes of treatment, payment or healthcare operations. Healthcare information may be released to any person or entity liable for payment on the patients' behalf to verify coverage or payment questions or for any purpose related to benefit payment.

HIPAA Notice of Privacy Practices: We understand the information you provide to us is private and personal. We are committed to protecting your Personal Health Information (PHI). We are required by law to keep your PHI private and provide you with a copy of our Privacy Notice.

Certification of Responsible Party: The signature below certifies that the above statements have been read and that the Patient, Patient Parent/Guardian, or Responsible Party accepts these terms. It also certifies that information provided by me is accurate and complete.

Signature of Patient/Responsible Party_____**Today's Date**_____

Printed Name of Responsible Party_____**Relationship to Patient**_____

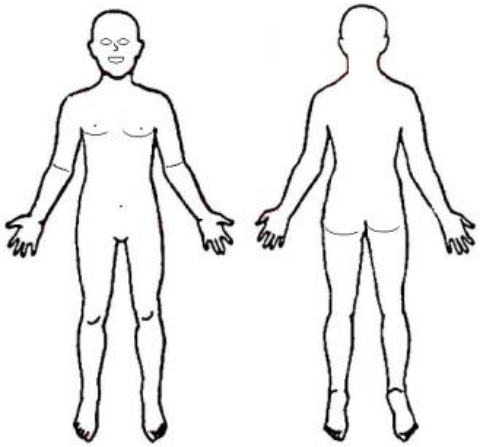
PATIENT INITIAL HEALTH QUESTIONNAIRE

PATIENT NAME _____ DATE OF BIRTH_____ DATE_____

1. Are you CURRENTLY being treated for other diagnosed medical problems?____Yes___No
   If yes, please elaborate_____
2. Please circle any conditions that you HAVE or HAVE HAD in the past:

Diabetes	MS	Difficulty Urinating
Neuropathy	Pacemaker	Low Back Pain
Difficulty Walking	High Blood Pressure	Neck Pain
Circulatory Problems	Dizziness	Headaches
Seizures	Nausea	Osteoporosis
Asthma	Unexplained Weight Change	Cancer *(Stable? ___Yes___No)*
Breathing Difficulties	Loss of Bladder or Bowels	

3. Do you have arthritis? _____YES _____NO If yes, what kind_____
4. Do you have heart problems? _____YES _____NO
   If yes, please elaborate_____
5. Are you currently pregnant? _____YES _____NO If so, when is your estimated due date? _____/_____/_____
6. Please list all current medications_____
   _____
7. Please list all allergies_____
8. What is your: Height_____ Weight_____
9. Have you fallen in the last 12 months? _____YES _____NO If yes, when_____
10. Please list all previous surgeries (Related or Unrelated)_____
    _____
11. Shade in or circle areas of pain or abnormal sensation:



Rate your pain at WORST and BEST:
(0=No Pain, 10=Emergency Room Pain)

0 1 2 3 4 5 6 7 8 9 10

12. Do you have any numbness or tingling? _____ YES _____NO
    If yes, please elaborate where_____
13. What activities increase your symptoms?_____
14. What does your pain limit you from doing?_____
15. What decreases your symptoms?_____
16. When did your symptoms start?_____
17. What is your occupation?_____
18. Have you ever been treated for Physical or Occupational Therapy? _____YES _____NO
19. Is the problem you are being treated for involved in litigation? (lawsuit) _____YES _____NO
20. Are you suffering from depression or any other mental illness? _____YES _____NO If yes, have you sought medical care? _____YES _____NO Is it related to your current injury? _____YES _____NO
21. How did you hear about Canyon View Physical Therapy?_____