

New Patient Information and Agreement

Please Read Carefully

Welcome to STI Physical Therapy and Rehabilitation. We are a full service physical rehabilitation company with licensed physical, occupational and hand therapists, licensed athletic trainers, exercise physiologists and strength and conditioning specialists. In addition, many of our practitioners hold advanced degrees and specialty credentials.

Your physician, employer or other healthcare professional, has most likely referred you to us. It is our policy and responsibility to keep your referring party informed of your plan of care, status and progress. Please be advised that third parties such as our clinical or office staff, your physician(s), your insurance company representative(s), third-party provider network administrators, or legal counsel may have access to your pertinent medical records. In the case of industrial injuries, your employer or its representative(s), your legal counsel, or your medical case manager(s) may also have access to your medical record. Only information specific to the reason we are treating you for will be released. Otherwise, we will maintain your privacy by keeping your records confidential to unauthorized persons or entities. Prior to release of your medical records from any unknown entity, we will first seek your permission in writing. This policy is put in place to protect you and to comply with federal and state regulations.

We are here to provide the help, skill and knowledge you will need on your road to recovery and optimal functioning. Our business is to enhance the healing process and to assist you in returning to full participation in the things that mean the most to you. Our goal is to provide quality, individualized and effective care. We intend on keeping the "care" in healthcare.

As a partner in this program we will need your help and full participation. You are the most important component in the healing process and we are here to facilitate that process. During your course of therapy you may be instructed in exercises or procedures to perform at home or work and we will ask for your compliance. In addition, we operate by scheduled appointments so we will ask that you do your best to be on time for your treatment sessions. Late attendance makes it difficult for our staff to effectively treat you and it creates conflicts with other scheduled patients. If you are going to be late or need to change/cancel an appointment please notify us as soon as possible. We encourage make-up of any missed appointment to ensure our treatment plan is not interrupted. Thank you for your consideration and courtesy.

Once again, welcome to our facility. Please feel at home and comfortable. We look forward to serving you.

Yours in Health,
Mark Hyland
Director of Rehab

Whom can we thank for the pleasure of meeting you?

Doctor Nurse Employer Former Patient Friend Yellow Pages Union
Other: _____

I consent that I have read and understand the above information.

Patient Signature

Date

STI Physical Therapy & Rehabilitation

Please **Complete** Each Item on This Registration Form

PT ID#: _____

If the **patient is a minor**, a parent or guardian must SIGN bottom of this form.

Patient Name: _____ () _____
Last Name First Name Middle Home Phone No

E-Mail address: _____ () _____
Cell Phone No

Address: _____ Apt No.: _____ City: _____ State: _____ Zip: _____

Patient SS #: _____ Date of Birth: _____ Male: _____ Female: _____ Marital Status: _____

Current Employer: _____ Address: _____ Phone Number: _____

Prescribing Physician: _____ Telephone No: _____ Fax No: _____

EMERGENCY INFORMATION:

Relative Living/Not Living With You: _____ Relation _____ Phone # _____

INJURY INFORMATION must be completed. Then complete appropriate insurance information section

Is the Injury related to: AUTO ACCIDENT? _____ WORK RELATED? _____ OTHER? _____ Date of Injury: _____

Injured Part of Body: _____ Occupation (Description of Duties) _____

AUTO OR PERSONAL INJURY INFORMATION: (For injuries related to a motor vehicle or personal injury accident)

Please complete supplemental forms

WORKER'S COMPENSATION INFORMATION: (To be completed for work-related injuries)

Employer @ Time of Injury: _____ Supv/Mgr: _____ Date of Injury: _____

Industrial Insurance Carrier: _____ Claim Number: _____

Case Manager/Nurse/Claim Adjuster: _____ Telephone No: _____

INSURANCE (Guarantor) INFORMATION: This section must be as complete as possible.

Responsible Party SS# _____ Relationship to Insured: Self _____ Spouse _____ Child _____ Other _____

Primary Insurance: _____ Insured Name: _____

Insurance Phone No: _____ ID Number: _____

Group Number: _____ Insured's DOB: _____ Employer: _____

Secondary Insurance: _____ Insured Name: _____

Insurance Phone No: _____ ID Number: _____

Group Number: _____ Insured's DOB: _____ Employer: _____

***Are you receiving any services at home? YES NO If YES we need: Home Health Care Agency**

Name _____ Telephone No. _____

***Have you had Physical or Occupational Therapy services anywhere else this year? _____**

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).

2. I authorize my insurance carrier to release information regarding my coverage to STI Physical Therapy/Strength Training Inc. I also authorize agents of any hospital, treatment center or previous physicians to furnish STI Physical Therapy/Strength Training Inc copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any physician or insurance carrier as needed.

3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and medical services including major medical benefits are hereby assigned to STI Physical Therapy/Strength Training Inc. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to STI Physical Therapy/Strength Training Inc

Patient Signature: _____ Date/Time: _____ AM or PM (circle one)

Responsible Party Signature: _____ Relationship: _____ Date/Time: _____ AM or PM (circle one)



Accident/Injury Request for Additional Information Waiver

Is the Physical Therapy care you are receiving at STI Physical Therapy and Rehabilitation the result of a Motor Vehicle Accident (MVA), Other Accident or Injury?

Yes _____ No _____ Date of Injury/Accident _____

If **"NO"** Please explain the reason you are being treated at STI Physical Therapy and Rehabilitation in the space below. Once complete, please sign and date this form to confirm that your treatment is **NOT** the result of an auto accident or injury. (This form used for Insurance purposes)

Where did this injury/accident occur? _____

What area are you being treated for? _____

Is there 3rd party liability _____ Yes or _____ No

Signature: _____ Date: _____

Printed Name: _____ Date: _____

If "YES" please continue to the next page and complete the accident/injury questionnaire.

CORPORATE

17233N. HOLMES Blvd., Suite 1650. PHOENIX, AZ 85053. 602-547-1836. FAX 602-547-0809

Accident/Injury Request for Additional Information:

Explain the Details of the Accident or Injury:

Was the accident or injury: Motor Vehicle ___ Work Related ___ Other ___

If Other, please describe: _____

When did the accident occur? Date: _____ Time _____ AM/PM

Where did the accident occur? _____ City and State: _____

How did the accident occur? _____

Was the accident work related? Yes ___ No ___ Was the accident a MVA related to work? Yes ___ No ___

Were there any citations issued? Yes ___ No ___

Responsibility Party Information (Person determined to be at fault):

Name of the responsible party if other than the patient (or guardian) _____

What is the relationship of the responsible party to the patient? _____

Responsible Party Address: _____

Phone# _____ Insurance: _____

Policy Holder (if different than the responsible party): _____

Insurance Phone # _____ Claim# _____

Additional Information for MVA Related Injuries:

Patient was the Driver ___ Passenger ___ Pedestrian ___

Was the patient wearing a seat belt? Yes ___ No ___

Patient Auto Insurance is: _____

Does the patient have MedPay Coverage? Yes ___ No ___ Unknown ___

Med Pay Insurance: _____

Policy # _____ Is there a claim filed: Yes ___ No ___

Claim# _____ Date Filed: _____

Adjuster's Name: _____ Phone#: _____

Is there a Police Report? Yes ___ No ___ Report # _____

*If Yes, Please provide a copy of this report for our billing department

Additional Information for Attorney Representation:

Has the patient hired an Attorney regarding this accident? Yes ___ No ___

Attorney Name: _____

Address: _____

Telephone # _____

Please sign below to certify that the foregoing is true and correct to the best of your knowledge:

Patient or Guardian _____ Date: _____
Printed Name: _____ Date: _____

STI Employee Witness: _____ Date: _____
STI Employee Printed Name: _____ Date: _____

LIEN ASSIGNMENT

Attorney:

Provider:

Strength Training, Inc
17233 N. Holmes Blvd.
Phoenix, AZ. 85053
Phone _____ (Service Location)
Fax: 602-547-2806

I hereby authorize and direct you, my attorney, to pay directly to Strength Training, Inc. such sums as may be due and owing them for medical services rendered to me both by reason of this accident and by reason of any other bills that are due their office, and to withhold such sums from any settlement, judgement, or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to Strength Training, Inc for all medical bills submitted by them for services rendered to me and that this agreement is made solely for Strength Training, Inc.'s additional protections and in consideration of their awaiting payment. And I further understand that such payment is not contingent on any settlement, judgement, or verdict by which I may eventually recover the said fee.

I do hereby authorize Strength Training, Inc. to furnish you, my attorney, with a full report of their examination, diagnosis, treatment, prognosis, etc., of myself in regard to this accident in which I was involved.

By initialing below, I am **authorizing Strength Training, Inc. to bill the insurance I have provided them.** I fully understand that should said insurance decline coverage as a result of the accident in which I was involved, I am responsible for payment of my account to Strength Training, Inc.

Dated: _____

Initials: _____

OR

By initialing below, I **decline to have insurance billed OR do not have any insurance to bill** for the medical bills incurred at Strength Training Inc., as a result of the accident in which I was involved.

Dated: _____

Initials: _____

I fully agree to all the terms and conditions set forth in the above written paragraphs.

Dated: _____

Patient Signature: **X** _____

Account Number # _____

Print Patient Name: _____

The undersigned, being the attorney of record for the above-named patient, does hereby agree to observe all of the terms of the above and agrees to withhold such sums from any settlement, judgement, or verdict as may be necessary to adequately protect Strength Training, Inc. I also agree to the patient's decision with regards to insurance billing.

Dated: _____

Attorney Signature: **X** _____

Attorney: Please date, sign, and return the original of this assignment to Strength Training, Inc. keeping one copy for your records.

*****NOTE*****

Strength Training Inc. is an independent physical therapy provider and is incorporated in the state of Arizona. It is not a subsidiary of any other healthcare provider or physician's office. It is not our general policy to issue monthly statements on accounts where there is a lien on file. If your office would like to receive a monthly statement on the above-referenced patient, please contact this office immediately via phone or fax.

STI Physical Therapy and Rehabilitation Medical History Information

The purpose of this form is to obtain medical information for your therapist in order to provide you with effective and safe treatment. Please complete sections 1 – 4 as thoroughly as possible. If you have any concerns about disclosing information about yourself please discuss with your therapist.

Section 1.

Present condition you were referred to us for: _____

Recent diagnostic testing for current condition (if you have a copy of report please provide to your therapist): X-ray MRI

CT EMG/Nerve Conduction Other (describe): _____

Section 2. Please mark yes or no to all current or previous conditions.

	Yes	No		Yes	No
Diabetes	<input type="radio"/>	<input type="radio"/>	Stroke	<input type="radio"/>	<input type="radio"/>
Cancer	<input type="radio"/>	<input type="radio"/>	Vision Problems	<input type="radio"/>	<input type="radio"/>
Gout	<input type="radio"/>	<input type="radio"/>	Hearing Problems	<input type="radio"/>	<input type="radio"/>
Kidney problems	<input type="radio"/>	<input type="radio"/>	Emotional/Psychological issues	<input type="radio"/>	<input type="radio"/>
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	Ulcer/Stomach Problems	<input type="radio"/>	<input type="radio"/>
Heart Trouble	<input type="radio"/>	<input type="radio"/>	Bowel/Bladder Problems	<input type="radio"/>	<input type="radio"/>
Pacemaker	<input type="radio"/>	<input type="radio"/>	Pneumonia	<input type="radio"/>	<input type="radio"/>
Bleeding disorder	<input type="radio"/>	<input type="radio"/>	Arthritis	<input type="radio"/>	<input type="radio"/>
Asthma/Hay fever	<input type="radio"/>	<input type="radio"/>	Phlebitis	<input type="radio"/>	<input type="radio"/>
Epilepsy/Seizures	<input type="radio"/>	<input type="radio"/>	Back Problems	<input type="radio"/>	<input type="radio"/>
Neurological Disease(s)	<input type="radio"/>	<input type="radio"/>	Neck Problems	<input type="radio"/>	<input type="radio"/>
HIV/Aids	<input type="radio"/>	<input type="radio"/>	Traumatic Head Injury	<input type="radio"/>	<input type="radio"/>
MRSA	<input type="radio"/>	<input type="radio"/>	Broken Bones	<input type="radio"/>	<input type="radio"/>
Skin Conditions	<input type="radio"/>	<input type="radio"/>	Swallowing Problems	<input type="radio"/>	<input type="radio"/>
COPD	<input type="radio"/>	<input type="radio"/>	Pregnant or may be Pregnant?	<input type="radio"/>	<input type="radio"/>
Hepatitis	<input type="radio"/>	<input type="radio"/>	Do you consume alcohol?	<input type="radio"/>	<input type="radio"/>
Do you smoke?	<input type="radio"/>	<input type="radio"/>	Other	<input type="radio"/>	<input type="radio"/>
If other please explain: _____					

Section 3.

Previous Surgery Date(s): _____

Previous Therapy Date(s): _____

Chronic Illnesses: _____

Allergies: _____

Current Medications (include OTC, herbal and nutritional supplements): _____

Section 4. **IMPORTANT**

Please list any individuals you authorize to inquire about and or schedule your appointments at STI Physical Therapy.

By signing below you confirm that the information above is accurate to the best of your knowledge.

Name (print): _____

Signature: _____

Date: _____

HIPAA CONSENT

STI Physical Therapy and Rehabilitation

Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by Requesting in writing to the Privacy Officer – 17233 N Holmes Blvd Suite 1650, Phoenix – Arizona 85053.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. This consent shall remain in effect for an unlimited duration unless/until revoked by the patient. You have the right to revoke this consent, in writing, and takes effect immediately except where we have already made disclosures in reliance on your prior consent. Such revocations do not extend to actions already taken in reliance on the consent (e.g., a revocation after treatment, but before payment for that treatment).

By signing this form, you also acknowledge receipt of STI Physical Therapy and Rehabilitation Privacy Notice.

Patient Signature Date

Witness Signature Date

Patient Name (Printed) Date

Witness Name (Printed) Date