Welcome to STI Physical Therapy.
Thank You for trusting us with your care.

To better serve you and our community,
please take a moment to tell us how you heard of us.

Please check any and all boxes that apply.

- Attorney
- Bike Race
- Employer
- Facebook
- Free Injury Assessment
- Friend/Family Member
- Google
- Internet / Website
- Health Connections
- Other *(Please Specify)*
- Health Fair
- Physician
- Print Ad *(newspaper/Mag. Etc.)*
- Referral Service
- School
- Twitter
- Veterans Administration
- Yellow Pages
- Yelp

Thank You and we look forward to serving you
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
PT ID: __________________

Please Complete Each Item on This Registration Form

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

Patient Name: ____________________________ First Name: ____________________________ Middle: ____________________________ Last Name: ____________________________ 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: ____________________________
Injured body part: ____________________________

EMERGENCY INFORMATION
Relative Living/Not Living With You: ____________________________ Relation: ____________________________ Phone #: ____________________________

FINANCIAL RESPONSIBILITY
Is there a party other than yourself or your health insurance that is responsible for the payment of these visits? If Yes ___ (go to page 2). If No ___(complete insurance information below)

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: ____________________________

PREVIOUS AND/OR CURRENT REHABILITATION SERVICES
Are you receiving any services at home? YES NO If YES please provide name of Home Healthcare Agency
Name: ____________________________ Telephone No: ____________________________
Have you had rehabilitation services anywhere else this year? ________ (i.e. physical, occupational, speech, cardiac )

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)
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 1640, 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.

<table>
<thead>
<tr>
<th>Patient Signature</th>
<th>Date</th>
<th>Witness Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name (Printed)</td>
<td>Date</td>
<td>Witness Name (Printed)</td>
<td>Date</td>
</tr>
</tbody>
</table>

HIPAA Patient Consent Form STI REV 2011
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. If you have any medical records related to the condition we are seeing you for please provide us with copies. It will help enhance your experience with us.

Section 1
Height: _______  Weight: _______

Present problem(s) you are seeing us for: __________________________________________

When did your symptoms begin: __________________________________________

Recent diagnostic testing:  X-ray  MRI  CT  EMG/Nerve Conduction  Other: ______________________

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>o</td>
<td>o</td>
<td>Stroke</td>
<td>o</td>
</tr>
<tr>
<td>Cancer: Type</td>
<td>o</td>
<td>o</td>
<td>Vision Problems</td>
<td>o</td>
</tr>
<tr>
<td>Gout</td>
<td>o</td>
<td>o</td>
<td>Hearing Problems</td>
<td>o</td>
</tr>
<tr>
<td>Kidney problems</td>
<td>o</td>
<td>o</td>
<td>Emotional/Psychological issues</td>
<td>o</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>o</td>
<td>o</td>
<td>Ulcer/Stomach Problems</td>
<td>o</td>
</tr>
<tr>
<td>Heart Trouble</td>
<td>o</td>
<td>o</td>
<td>Bowel/Bladder Problems</td>
<td>o</td>
</tr>
<tr>
<td>Pacemaker</td>
<td>o</td>
<td>o</td>
<td>Pneumonia</td>
<td>o</td>
</tr>
<tr>
<td>Bleeding disorder</td>
<td>o</td>
<td>o</td>
<td>Arthritis</td>
<td>o</td>
</tr>
<tr>
<td>Asthma / Hay Fever</td>
<td>o</td>
<td>o</td>
<td>Osteoporosis / Osteopenia</td>
<td>o</td>
</tr>
<tr>
<td>Epilepsy/Seizures</td>
<td>o</td>
<td>o</td>
<td>Back Problems</td>
<td>o</td>
</tr>
<tr>
<td>Neurological Disease(s)</td>
<td>o</td>
<td>o</td>
<td>Neck Problems</td>
<td>o</td>
</tr>
<tr>
<td>Immunodeficiency Disorder/HIV</td>
<td>o</td>
<td>o</td>
<td>Traumatic Head Injury</td>
<td>o</td>
</tr>
<tr>
<td>MRSA</td>
<td>o</td>
<td>o</td>
<td>Broken Bones</td>
<td>o</td>
</tr>
<tr>
<td>Skin Conditions</td>
<td>o</td>
<td>o</td>
<td>Swallowing Problems</td>
<td>o</td>
</tr>
<tr>
<td>COPD</td>
<td>o</td>
<td>o</td>
<td>Pregnant or may be Pregnant?</td>
<td>o</td>
</tr>
<tr>
<td>Hepatitis</td>
<td>o</td>
<td>o</td>
<td>Spine Fusion</td>
<td>o</td>
</tr>
<tr>
<td>Do you smoke?</td>
<td>o</td>
<td>o</td>
<td>Joint Replacement</td>
<td>o</td>
</tr>
</tbody>
</table>

Section 3
Previous Surgery Date(s): ______________________

Previous Treatment for Current Condition(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 with us.

__________________________________________

By signing below you confirm that the information above is accurate to the best of your knowledge and you will notify your supervising therapist of any changes herein.

Name (print): __________________________________________

Signature: __________________________________________  Date: __________

P:\Forms\2011 Forms\New Patient Packet\5 page new patient packet\STI Medical History Information Form 2014.docx
Please Complete Each Item on This Registration Form

Section 1
Date of Injury: ______________________

City and State Where Accident Occurred: ______________________

Type of Accident  (check all that apply)

Auto Accident  Slip and Fall  Hit and Run  Product Liability
Recreational Vehicle  Work Related  (go to Section 2)
Homeowners Liability  Other Personal Injury

Do you have an attorney?  If yes________(complete separate Lien Form) No________

Accident Details:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Section 2
WORKER’S COMPENSATION INFORMATION: (To be completed for work-related injuries)

Employer at Time of Injury: ______________________  Supv/Mgr: ______________________

Industrial Insurance Carrier: ______________________  Claim Number: ______________________

Adjuster: ______________________  Nurse Case Manager: ______________________

Telephone: ______________________  Telephone: ______________________

Fax: ______________________  Fax: ______________________
Patient Comfort Assessment Guide

Name: ________________________________ Date: ______________

1. Where is your pain?

2. Circle the words that describe your pain.
   - aching
   - throbbing
   - shooting
   - stabbing
   - gnawing
   - sharp
   - tender
   - burning
   - exhausting
   - tiring
   - penetrating
   - nagging
   - numb
   - miserable
   - unbearable

Circle One
   - occasional
   - continuous

What time of day is your pain the worst?
   - morning
   - afternoon
   - evening
   - nighttime

3. Rate your pain by circling the number that best describes your pain at its worst in the last month.
   - No Pain
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - 10
   - Pain as bad as you can imagine

4. Rate your pain by circling the number that best describes your pain at its least in the last month.
   - No Pain
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - 10
   - Pain as bad as you can imagine

5. Rate your pain by circling the number that best describes your pain on average in the last month.
   - No Pain
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - 10
   - Pain as bad as you can imagine

6. Rate your pain by circling the number that best describes your pain right now.
   - No Pain
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - 10
   - Pain as bad as you can imagine

7. What makes your pain better?
   ____________________________________________________________

8. What makes your pain worse?
   ____________________________________________________________

9. What treatments or medicines are you receiving for your pain? Circle the number to describe the amount of relief the treatment or medicine provide(s) you.

   a) ________________________________ No 0 1 2 3 4 5 6 7 8 9 10 Complete
   Treatment or Medicine (include dose) Relief

   b) ________________________________ No 0 1 2 3 4 5 6 7 8 9 10 Complete
   Treatment or Medicine (include dose) Relief

   c) ________________________________ No 0 1 2 3 4 5 6 7 8 9 10 Complete
   Treatment or Medicine (include dose) Relief

   d) ________________________________ No 0 1 2 3 4 5 6 7 8 9 10 Complete
   Treatment or Medicine (include dose) Relief
Accident/Injury Request for Additional Information Waiver
This form is used for insurance purposes

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.

____________________________________
____________________________________
____________________________________

Where did the injury/accident occur? __________________________

What area are you being treated for? __________________________

Is there 3\textsuperscript{rd} party liability? Yes ________ No ________

Patient's Name: __________________________

Patient/Responsible Party Signature: __________________________

Date: __________________________

CORPORATE
17233 N. Holmes Blvd., Suite 1650 – Phoenix, AZ 85053 – (602) 547-1847 – Fax (602) 547-0809
PATIENT RIGHTS

The Patient Has A Right To:

- All patients will be treated with dignity, respect and consideration.
- Not to be discriminated against in regard to race, national origin, sexual orientation, religion, disability, economic status, gender, marital status or diagnosis.
- To be free from all forms of abuse, neglect, exploitation, coercion, manipulation, sexual abuse or assault, physical restraint or seclusion except as allowed in R9-10-1012(B) or harassment.
- Receive information from their therapist/clinician about their illness, injury, course of treatment, and prospects for recovery in terms that they can understand that includes their individual choices, strengths and abilities.
- Receive as much information about any proposed treatment or procedure as they may need in order to give informed consent or refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternate courses of treatment of non-treatment and the risks involved in each, and to know the name of the person who will carry out the procedure or treatment.
- Participate actively in decisions regarding their medical care. To the extent permitted by law, this includes the right to refuse treatment.
- Full consideration of privacy concerning their program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence for any individual.
- Except as otherwise permitted by law, written consent will be required by the patient to release any medical records to themselves or outside entities.
- Reasonable responses to any appropriate requests they make for service.
- Leave the clinic even against the advice of the medical staff.
- Reasonable continuity of care and to know in advance the time and location of appointment, as well as the therapist / clinician providing the care.
- Be informed by their therapist, clinician or a delegate concerning health care requirements following discharge from the clinic.
- To participate or refuse to participate in any treatment, research or experimental treatment.
- Have all patients’ rights apply to the person who may have legal responsibility to make decisions regarding medical care.
- Submit complaints without reprisal or retaliation.
- Misappropriation of personal and private property by clinic personnel, employee, volunteer or student.
- Consents to photographs before a photo is taken, except during admission/registration for identification purposes.

PATIENT RESPONSIBILITIES

- To give your clinician and Clinic complete and accurate information about your condition and care. Follow your therapist’s orders and instruction and the Clinic nursing staff’s instruction for your care.
- Ask questions when you do not understand information or instructions.
- To be considerate of other patients and STI’s clinic staff who are caring for you.
- To be responsible for your valuables by sending them home or leaving them in the care of family members or friends.
- Tell your clinician or staff member if you feel you cannot follow through with your treatment and accept responsibility for refusing treatment. Ask your therapist about the risks and consequences for refusal prior to making decisions.
- To supply up-to-date insurance information and pay your bill promptly.
- To supply your therapist and Clinic up-to-date information on your address and phone so we can follow you on your care.

Complaints regarding services can be made to: Arizona Department of Health Services 150 North 18th Avenue, Suite 450, Phoenix, AZ 85007. General & public Information: 602-364-3030.

Patient or Legal Guardian Signature: ___________________________ 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 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.

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