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
- ☐ Health Fair
- ☐ Physician
- ☐ Print Ad (newspaper/Mag. Etc.)
- ☐ Referral Service
- ☐ School
- ☐ Twitter
- ☐ Veterans Administration
- ☐ Yellow Pages
- ☐ Yelp
- ☐ Other (Please Specify) _____

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: _____ _____ _____ (____) _____
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: _____

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.

Patient Signature	Date	Witness Signature	Date
Patient Name (Printed)	Date	Witness Name (Printed)	Date

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.

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

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: _____

PT ID: _____

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 _____

Hit and Run _____

Recreational Vehicle _____

Homeowners Liability _____

Slip and Fall _____

Product Liability _____

Work Related _____ (go to Section 2)

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: _____

Telephone: _____

Fax: _____

Nurse Case Manager_____

Telephone: _____

Fax: _____

Patient Comfort Assessment Guide

Name: _____ Date: _____

1. Where is your pain? _____

2. Circle the words that describe your pain.

aching	sharp	penetrating
throbbing	tender	nagging
shooting	burning	numb
stabbing	exhausting	miserable
gnawing	tiring	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 Relief

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

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

d) _____ No 0 1 2 3 4 5 6 7 8 9 10 Complete
Treatment or Medicine (include dose) Relief 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 3rd 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 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 <u>authorizing</u> 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 <u>decline</u> 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.