PATIENT INFORMATION FORM										
Patient Name (Last, First, Mi)		Date								
SS#		Drivers License #		State						
D.O.B.		Age		Sex		Single ☐	Married ☐	Divorced ☐	Separated ☐	Widow ☐
Street		City		State		Zip				
Email Address		Cell Phone		Work Phone						

Guardian Information (Responsibility Party)					
Grantor Name (Last, First, Mi)		Relationship		Date	
SS#		Drivers License #		Cell Phone	
D.O.B.		Age		Sex	
		Work Phone			
Employer		Relationship		Email	
Street		City		State	

Additional Information	
Referring Doctor (Name, Location)	
Family Doctor (Name, Location	
Emergency Contact (Relation, Phone)	

Primary Health Insurance											
Primary Carrier		Mailing Address									
ID #		Group #		Employer							
Policy Holder		Sex		Relationship		D.O.B.		S.S.#			

Secondary Health Insurance									
Secondary Carrier		Mailing Address							
ID #		Group #		Employer					
Policy Holder		Sex		Relationship		D.O.B.		S.S.#	

I certify that the all information is correct. I understand that I am personally responsible to pay all charges for services rendered to me and agree to make payment, thereof, when due. Any billing sent by the provider to an insurance company, attorney, or other third party is for the accommodation of the patient and does not relieve the undersigned to pay charges for services provided.

I authorize payment for these services be paid directly to ELITELEVELPT.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

Patient: ____ Date: ________________

Guardian/Responsible Party: ____ Date: _______________

Health History

Patient Name (Last, First, Mi)		Date	

Age		Height		Weight	
Do you have a pacemaker?		Do You Smoke?		Are you latex sensitive?	

ALLERGIES

MEDICATIONS (Include pills, Injections and/or skin patches)

Have you ever taken steriod medications for any medical conditions?

Have you ever taken blood thinning or anticoagulant medications for any medical conditions?

SURGERIES INJURIES, AND HOSPITALIZATIONS?

Diagnostic Test (for example: x-ray, MRI, CT Scan, Bone Scan, blood test)

Treatment received so far for this injury, pain or problem?

Occupation, including activities that comprise your work day?

Are you on work restriction from your doctor? Yes or No If yes please explain:

Leisure activities including exercise?

WOMEN ONLY: Are you currently pregnant or think you might be pregnant? **YES or NO**

Have you RECENTLY experienced any of the following? (Check all that apply)

	Fatigue		Falls		Constipation		Heartburn/indigestion
	Fever/Chills		Numbness or tingling		Diarrhea		Difficult Swallowing
	Nausea/Vomiting		Muscle weaknes		Shortness of breath		Changes in bowel or bladder funtion
	Difficulty maitaining balance while walking		Dizziness or lightheadedness		Fainting		
					Cough		Changes in bowel or bladder funtion
			Headaches		Weigh loss/gain		

Have you EVER been diagnosed with any of the following conditions ? (Check all that appy)

	AIDS/HIV		Anemia		Angina		Arteriosclerosis
	Arthritis		Asthma		Blood Clots		Bone Infection
	Cancer		Chemical Dependency		Circulation Problems		Depression
	Diabetes		Epilepsy		Eye Infection		Heart Problems
	Hemophilia		High/Low Blood Pressure		Joint/Bone Infection		Liver Problems
	Lung Issues		Multiple Sclerosis		Musculoskeletal Problems		Pneumonia
	Stroke		STD		Tuberculosis		Urinary Infection

Anything not list above, please list here:

Have anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the folowing conditions (check all that apply)							
	Cancer		Diabetes		Tuberculosis		Other:
	Heart Problems		Stroke		Thyroid problem		
	Blood Clots		High/Low Blood Pressure		Depression		

MARK AREA OF DISCOMFORT (Please mark the areas where you feel symptons on the chart to the below)

Aggravated factors: Can you identify positions and activities that make your symptoms worse?
1)
2)
3)

Symptom relieving factors: Can you identify positions and activities that make your symptoms better?
1)
2)
3)

How are you currently able to sleep at night due to your symptoms?							
	No Problem		Difficulty		Awakened by pain		Sleep only w/medication

When are your symptoms worst?									
	Mornning		Afternoon		Evening		Night		After

When are your symptoms the best?									
	Mornning		Afternoon		Evening		Night		After

Using the 0 to 10 scale, with 0 being "NO PAIN" and 10 being "EMERGENCY ROOM PAIN" plesase describe below											
Your current level of pain while completing this survey:	0	1	2	3	4	5	6	7	8	9	10
The worst your pain has been during the last 24 hours:	0	1	2	3	4	5	6	7	8	9	10

Have you ever had this injury before:	YES or NO	When:		Treatement:	

PATIENT INFORMATION AND CONSENT FORM

CONSENT FOR CARE AND TREATMENT: I hereby agree and give my consent to ELITELEVELPT Home of the PASS Program to furnish appropriate rehabilitative care and treatment, as considered necessary and in the best interest in order to attend to the physical condition. I understand that the benefits and risks to all interventions will be explained and that the patient holds the final judgment in such matters.

If under 18, Parent/Guardian: ____

Relationship to Patient: ___________________________ Parent/Guardian Date of Birth: ______________________

MEMBER DIRECT PAYMENT NOTIFICATION: Arizona state constitution permits you to pay a healthcare provider for health care services directly. If you have any active health insurance coverage, please review the provider's policies regarding payment before you make any arrangements to pay directly. By signing below, I agree to have my physical therapy claims submitted to the medical insurance carrier that I have supplied.

AUTHORIZATION TO PAY: I hereby authorize insurance payment directly to ELITELEVELPT Home of the PASS Program, Billing Department, 3555 W Pinnacle Peak Rd, Glendale, AZ 85310 for medical services rendered. I understand that I am financially responsible for the charges not covered by my insurance. In the event of default, I promise to pay collection costs and reasonable fees as may be required to obtain collection of this account.

ATTENDANCE AGREEMENT: Due to the nature of physical therapy, your progress and full recovery are dependent on both our experienced physical therapists, and your active participation and commitment to your appointments. If you need to cancel your appointment, please contact ELITELEVELPT Home of the PASS Program at least one day prior to your appointment. If you call to cancel your appointment on the same day as your appointment or if you do not show, a $25.00 cancellation fee will be assessed.

PHOTOGRAPHY/VIDEOGRAPHY AGREEMENT: I understand that in order to protect the confidentiality of our patients, there can be no filming, going "live" via social media or taking pictures of my treatment, or that of other patients, without prior authorization from the Clinic Director.

AUTHORIZATION TO COMMUNICATE ELECTRONICALLY: I understand that authorized personnel (including my physical therapist) from ELITELEVELPT Home of the PASS Program may communicate with me regarding scheduling/ appointments, the treatment provided, home exercise programs, and educational/informative content as it relates to my condition. I understand that my protected health information (PHI) will not be communicated electronically. I understand that I have the opportunity to opt-out of future communications at any time using the "unsubscribe" option on any communication via text or email.

By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document:

Printed Name: ____ Date: _____________________

Patient/Guardian Signature: _________________________________

NOTICE OF PATIENT INFORMATION PRACTICES

This notice describes how medical information about you may be used or disclosed and how you can get access to information. Please review it carefully.

ELITELEVELPT HOME OF THE PASS PROGRAM'S LEGAL DUTY

ELITELEVELPT Home of the PASS Program is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow these practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

ELITELEVELPT Home of the PASS Program uses your personal health information primarily for treatment; obtaining payment of treatment; conducting internal administrative activities, and evaluating the quality of care that we provide. For example, ELITELEVELPT Home of the PASS Program may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

ELITELEVELPT Home of the PASS Program may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, ELITELEVELPT Home of the PASS Program's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization through a written statement to stop future disclosures at any time.

ELITELEVELPT Home of the PASS Program may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the clinic and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate information or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. ELITELEVELPT Home of the PASS Program will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand ELITELEVELPT Home of the PASS Program's Notice of Information Practices.

- I understand that ELITELEVELPT Home of the PASS Program may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.
- I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice.
- I also understand that ELITELEVELPT Home of the PASS Program will consider requests for restriction on a case-by-case basis.
- I hereby consent to the use and disclosure of my personal health information for purposes as noted in ELITELEVELPT Home of the PASS Program's Notice of Information Practices.
- I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient: ____ Date: ________________

Guardian/Responsible Party: ____ Date: _______________