ELITE LEVEL PT

SPORTS PERFORMANCE & INJURY PREVENTION

PERSONAL INFORMATION

Name								Date			
Street			City		State			Zip			
SS#		Drivers License #				State					
D.O.B.		Age		Sex		Single ☐	Married ☐	Divorced ☐	Separated ☐	Widow ☐	
Home Phone		Mobile				Work Phone					
Employer		Occupation									
Emp. Address		City		State			Zip				

HISTORY

Excersise Frequency		Excersise Type			
Do you Smoke		Have you ever smoked		How often	
Are you pregnant		Do you have a pacemaker			
Allergies					
What medications are you currently using					
Previous complaints/ surgeries					
Previoius diagnoses/medication					

COMPLAINT

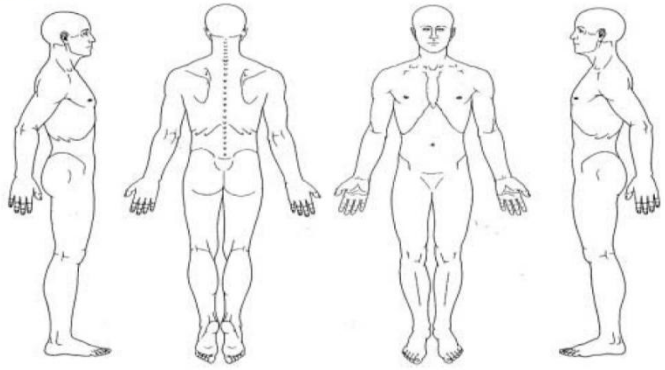
What is your major Complaint					
Start date		Possible Cause			
Symptoms					
Previous doctor seen for compaint					
Previous treatment for complaints					
Symptoms-Aggravating Factor					
Symptom-Relieving Factors					
Time of Day Symptoms are best		Time They are Worst			
Current Duration of Pain	Intermittent	Constant	With Certain Motions		
Current Level of Pain	Mild	Moderate	Severe	Excruciating	
Is your pain getting worst		Have you had this injury before			

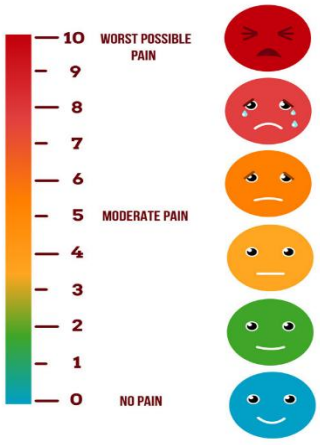
DO YOU HAVE ANY OF THE FOLLOWING

	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

MARK AREA OF DISCOMFORT

Please mark an X to indicate the areas where you feel pain, swelling, numbness or discomfort. Describe what you feel or observe in your own words. Write anywhere in this area.





SIGNATURE		DATE	

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 Foothills Sports Medicine 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.

WORKERS' COMPENSATION PATIENTS: We are required to inform your Workers' Compensation Adjuster and/or Rehabilitation Manager of all missed or canceled appointments. It is also required that all missed visits be rescheduled.

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: _____