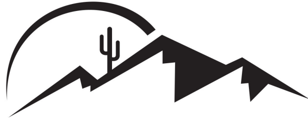


Patient & Billing Information

Patient Information

Name: Last______________________ First_____________________ Preferred _______________ Middle Initial_______

Gender ☐ M ☐ F Age _____ DOB ___ /___ /______ SSN ____________________ Student: ☐ Yes: FT / PT ☐ No

Marital Status: ☐ Married ☐ Single ☐ Other Race ____________ Language Preference _____________________

Address ____ City, State, Zip ______________________________

Phone Numbers: Home ______________________ Work ______________________ Mobile _______________________

Email ____ Preferred Phone ☐ Home ☐ Work ☐ Cell

Would you like appointment reminders? ☐Yes ☐No How would you like to receive them? ☐Voice ☐Email

How did you hear about us? ☐ Doctor ☐ Friend/Family ☐ Social Media/Online ☐ Other ____________

Please give us the name of the person who referred you so we can thank them! _______________________________

Referring Physician ________________________________ Primary Care Physician ________________________________

Billing Information

Responsible Party Name: Last_________________________ First_________________________ Middle Initial________

Phone Numbers: Home _______________________ Work ______________________ Mobile ______________________

SSN____________________________ DOB_________________ Relationship to Patient____________________________

Address ____ City, State, Zip ______________________________

Employer____

Employer Address ____ City, State, Zip ___________________________

Is this a Worker's Comp case? ☐ YES ☐ NO

Case # _____________________ Case Manager Name ___________________________ Phone ______________________

Insurance Information

Primary Insurance _______________________________

Phone ____

Address ____

Subscriber Name _________________________________

Subscriber Date of Birth ___________________________

Relationship to Patient ___________________________

Insured Policy ID # _______________________________

Group Number ___________________________________

Effective Dates ___________________________________

Secondary Insurance ____________________________

Phone ____

Address ____

Subscriber Name _________________________________

Subscriber Date of Birth ___________________________

Relationship to Patient ___________________________

Insured Policy ID # _______________________________

Group Number ___________________________________

Effective Dates ___________________________________

Emergency Contact

Name: Last____________________ First___________________ Relationship to Patient _________________________
Address____ City, State, Zip ______________________________
Phone Numbers: Home _____________________ Work _____________________ Mobile ______________________

Release of Information

I authorize Desert Edge Physical Therapy to provide my confidential health information to the following individuals:
Name: Last____________________ First___________________ Relationship to Patient _________________________
Name: Last____________________ First___________________ Relationship to Patient _________________________

Authorizations & Acknowledgements

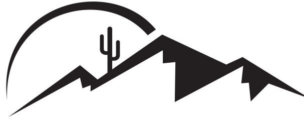
- ☐ I hereby certify that the above information is complete and accurate according to the best of my knowledge and ability.

- ☐ I understand that the information provided above may be used and shared for the purposes of treatment, billing for services rendered, and conducting of administrative operations of Desert Edge Physical Therapy per their **Notice of Privacy Practices** which I have had an opportunity to read, review, and receive.

- ☐ I give my consent to proceed with a therapy evaluation and corresponding treatment. I also give my consent that services may be observed and/or provided by a PT or PTA student under the supervision and instruction of a licensed physical therapist. Due to the nature of physical therapy and the physical exertion required to perform activities with increasing degrees of difficulty, I understand that there may be possible complications associated with my care such as an increase in my current level of pain, an aggravation of my existing injury, or very rarely, the development of a new injury. My signature below acts as a waiver of liability for treatment received at Desert Edge Physical Therapy excepting acts of negligence.

Patient/Guardian Signature: ______________________________________ Date: _________________________

Patient Name (Print): ____



Financial Policy

If your visit is related to an automobile or personal injury accident, please notify the front desk.

I understand it is my responsibility to understand my health insurance benefits, verify necessary referrals/authorizations are on file, and pay subsequent out of pocket expenses. I request and authorize my health insurance carrier to pay Desert Edge Physical Therapy for all charges related to services provided to me. I understand that I am entirely financially responsible to Desert Edge Physical Therapy for all services rendered and agree to pay in full any amounts not paid by an insurance company or other third party payer in addition to all co-payments, deductibles, or co-insurance which are due at time of service. All other payments are due 30 days after time of service. Should my account go to collections, I agree to pay all attorneys fees, court costs, filing fees, and all other charges that may be assessed. I further agree to pay interest in the amount of 1.5% per month on any balance over 90 days.

I understand that not showing for scheduled appointments will delay my plan of care, and that if I cannot attend one of my scheduled appointments, I must give a minimum of 24-hour notice when canceling. Failure to do so will result in a $25 fee.

Desert Edge Physical Therapy verifies insurance coverage and obtains a summary of insurance benefits for company purposes only. Although we may provide you with a copy of the benefits we were quoted, you are ultimately responsible for understanding your benefits. When we obtain a quote, we are given the following disclaimer: *This is an estimate of benefits only and in no way guarantees coverage or payment of claims*. If you have questions regarding your coverage, please call your insurance company.

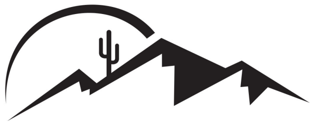
I understand that should my insurance benefits limit my physical therapy to a specific number of visits per year/condition, monetary amount, or require a referral or pre-authorization, it is MY responsibility to keep track of those numbers and verify with the front desk that the appropriate documents are on file. If I happen to go over my benefit limitations or neglect to verify authorizations/referrals are on file, I will be responsible for the entire balance on the exceeding visits or amounts.

I understand that regardless of insurance, I am responsible for the cost of all services rendered at Desert Edge Physical Therapy. Should my insurance company pay my claims at a different rate than was quoted to Desert Edge Physical Therapy and listed above, I will honor the actual assignment of benefits. If I am not satisfied with the actual assignment of benefits, it will be my responsibility to contact my insurance company.

I understand it is my responsibility to know which insurance is my primary carrier and which is my secondary. I recognize that Desert Edge Physical Therapy relies on the information I provide to obtain my benefits information. I verify that I have provided them with the correct info at the time of my visit.

My signature below verifies that I have not joined an HMO or other entity in which my Medicare/all other insurance benefits have been relinquished.

Patient/Legal Guardian Signature ___________________________________ Date ________________



Patient Medical Information

Patient Name:___________________________________ Age: ______________ Today's Date: ____________

Current Injury, Surgery, or Pain

Date of Injury: _______________ Date of Surgery: _______________ Date Pain Started: _______________

Referring Physician: ________________________ Last MD Visit: ___________ Next MD Visit: ___________

Is your injury related to any of the following?

☐ Work ☐ Car accident ☐ Surgery ☐ Lifting/Carrying ☐ Fall

☐ Slow onset ☐ Athletics ☐ Chronic/Reoccurring

Occupation: ______________________________________ Work Status: ☐ FT ☐ PT ☐ Unemployed

Diagnostics performed for this condition? ☐ X-ray ☐ MRI ☐ CT Scan ☐ EEG ☐ EMG ☐ Injections

If yes, date: ___________________

Have you received treatment for your condition before today? If yes, from whom: ____________________

☐ Medical Doctor ☐ Chiropractor ☐ Physical Therapist ☐ Other: ___________________

Have you recently experienced any of the following:

☐ Dizziness/Lightheaded
☐ Difficulty swallowing
☐ Muscle weakness
☐ Fainting
☐ Changes in bowl or bladder
☐ Numbness/Tingling
☐ Unexplained weight loss
☐ Incontinence
☐ Are you pregnant, # wks_______

Medical History

Have you ever been diagnosed with any of the following?

☐ High/Low blood pressure
☐ Heart problems
☐ Stroke/CVA
☐ Pacemaker
☐ Blood clots/Circulation issue
☐ Diabetes: Type 1/Type 2
☐ Osteoporosis
☐ Arthritis: OA/RA
☐ Cancer
☐ Bladder/Urinary/Kidney Disease

☐ Lung Problems COPD/Emphysema
☐ Tobacco use: #_____/day
☐ Asthma
☐ Seizures
☐ Neurological disease: MS/Parkinson's
☐ Depression/Anxiety/Panic
☐ Back pain: Degenerative/Stenosis/Herniation

☐ Back injury
☐ Neck injury
☐ Chronic headaches
☐ Other injury
☐ Fracture _____________
☐ TB/HIV/Hepatitis A, B, C
☐ Visual/Hearing Impaired
☐ Other condition: ____________________

Surgical History

☐ Joint Replacement(s) *please explain:*____ *date:* _____________

☐ Orthopedic Surgery *please explain:*____ *date:* _____________

☐ Heart Surgery *please explain:*____ *date:* _____________

☐ Fracture Repair *please explain:*____ *date:* _____________

☐ Spinal Surgery *please explain:*____ *date:* _____________

☐ Other Surgeries *please explain:*____ *date:* _____________

Current Medications

Please list your current medications:

☐ See attached list

Name	Dosage	Frequency
______________________________	______________	______________________________
______________________________	______________	______________________________
______________________________	______________	______________________________
______________________________	______________	______________________________
______________________________	______________	______________________________
______________________________	______________	______________________________
______________________________	______________	______________________________

I understand that it is important for my therapist to understand my medical history in order to create a comprehensive treatment plan. I certify to the best of my ability, the above information is complete and accurate.

Patient/Guardian Signature ________________________________ Date ____________________________

Patient Name ____

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