La Posada Out Patient Therapies
700 S. La Posada Circle
Green Valley, AZ 85614
(520)648-2200

Therapist:_____
EvaluationDate:_____
Time:_____

***Please bring the following items with you: *Prescription for therapy and your primary and secondary medical insurance Cards*.**
***If your medical insurance requires a co-payment, it must be paid upon check-in for each appointment. We accept Cash, Checks, and Visa or MasterCard**

(PLEASE PRINT)

Patient Name: _____ Patient Social #: _____

Gender: [_] Male [_] Female Birth Date: _____Age: _____Marital Status:_____

Mailing Address / City, State, Zip:_____

Alternate Address/ City, State, Zip:_____

Home Phone: (_____)_____ Other: (_____)_____ Email:_____

Parent/Guardian: _____ Relationship to Patient:_____

Primary Physician: _____ Referring Physician:_____

Employment Status:_____ Student: _____

Emergency Contact: _____ Relationship/Phone: _____

Insurance Information: *Please provide insurance card(s)*

Primary Insurance	**Secondary Insurance**
Insurance Name: _____	Insurance Name: _____
Policy ID#: _____	Policy ID#: _____
Policy Holder Name:_____	Policy Holder Name:_____
Policy Holder Social #: _____	Policy Holder Social #: _____
Policy Holder Birth Date: _____	Policy Holder Birth Date: _____
Relationship to Patient: _____	Relationship to Patient: _____
Policy Holders Employer: _____	Policy Holders Employer: _____

Workers Compensation
Accident Type: ( )Auto ( )Other ( )Employment Claim#_____
Date of Injury:_____Adjustor Name:_____ Phone number(____)_____

AUTHORIZATION TO RELEASE PATIENT INFORMATION: I hereby authorize La Posada Out Patient Therapies to release any personal health information (PHI) required in the course of my examination or treatment to the above stated insurance company, or their affiliates.

Signed (Patient or guardian)_____ Date_____

AUTHORIZATION TO PAY: I hereby authorize insurance payment directly to La Posada Out Patient Therapies, for medical services rendered. I understand that I am financially responsible for the charges not covered by my insurance(s). In the event of default, I promise to pay collection costs and reasonable fees as may be required to obtain collection of this account.

Signed (Patient or guardian)_____ Date_____

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Chief complaint: _____

Onset date of symptoms: _____ How did you injure yourself? _____

Current Work Status: **Full Duty** **Modified Duty** **Off Duty** **Disability** **Retired**

Occupation: _____ Is this a Work Comp Claim? **Yes** **No** Last date worked (if off duty): _____

Relevant surgeries/ joint replacements and dates: _____

_____

Diagnostic tests: X-Ray: ____MRI: ___CT: ___EMG: ___Doppler/Ultrasound: ___ Bone Density: ___Other: _____

Name of your Primary Care Practitioner (if different from who referred you to therapy): _____

Date of your next doctor's appointment: _____ Date of your next specialist's appointment: _____

Have you had prior therapy during this current calendar year? **YES** **NO** If yes, list approx. dates: _____

PLEASE CHECK/CIRCLE ALL THAT APPLY											
	Yes	**No**		**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
Diabetes			Thyroid Problems			Respiratory/Lung Problem			Skin Disorder/Rashes		
Hypoglycemia			Myofascial Pain Syndrome			Tuberculosis			Infectious Disease/MRSA		
Cancer			Fibromyalgia			Blood Clots/DVT			Chemical Dependency		
Liver Problems			Depression/Anxiety			Hypertension/ High BP			Rheumatoid Arthritis		
Hepatitis/Jaundice			Neurologic Disease			Pacemaker			Broken Bones/ Fracture		
Stomach Problems/ Ulcer			Head Injury/ Concussion			Rheumatic/Scarlet Fever			Osteoporosis/Osteopenia		
Bowel/Bladder Problems			Epilepsy/Seizures			Cardiovascular Disease			Dislocations		
Kidney Problems			Stroke/TIA			Wounds Open/Closed			Osteoarthritis/Gout		
Smoker/Tobacco Use			Learning Barriers			Blood Disorders			Exercise Regularly/ Healthy Diet		
WOMEN ONLY			Pregnant/Planning			Breast Feeding			Missed Menstrual Cycle		
			Swelling in Arms or Legs			Any form of Birth Control			Gynecological Problems		
MEN ONLY			Prostate Disease			Testicular Problems			Other:		

Please list current medications (Supplements, skin patches, or Injections): _____

Please list allergies and known adverse drug reactions: _____

Have you had any falls in the past 12 months? **YES** **NO** If so, How many? _____ Did your fall(s) result in injury? **YES** **NO**

If you have fallen in the past year, what caused your fall(s)? _____

Prior Functional Status: Independent Assistance Needed Totally Dependent

Home: Number of steps into home _____ Stairs _____ Number of people living at home with you? _____

Assistive Devices: Cane Walker Crutches Wheelchair Shower Chair Elevated Toilet Grab Bars

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Rate your **CURRENT** pain level on a scale of 0 to 10 (**0 is no pain and 10 is the worst pain you can imagine**)

0 1 2 3 4 5 6 7 8 9 10

Rate your pain level at **REST** on a scale of 0 to 10 (**0 is no pain and 10 is the worst pain you can imagine**)

0 1 2 3 4 5 6 7 8 9 10

Rate your pain level with **ACTIVITY** on a scale of 0 to 10 (**0 is no pain and 10 is the worst pain you can imagine**)

0 1 2 3 4 5 6 7 8 9 10

Rate your **CURRENT FUNCTIONAL** level 0 to 10 (**0 is no limitations and 10 means you need MAXIMAL assistance with daily activity**)

0 1 2 3 4 5 6 7 8 9 10

Please circle all that apply & Indicate the symptom location On the diagram.

A. Sharp B. Dull/Ache

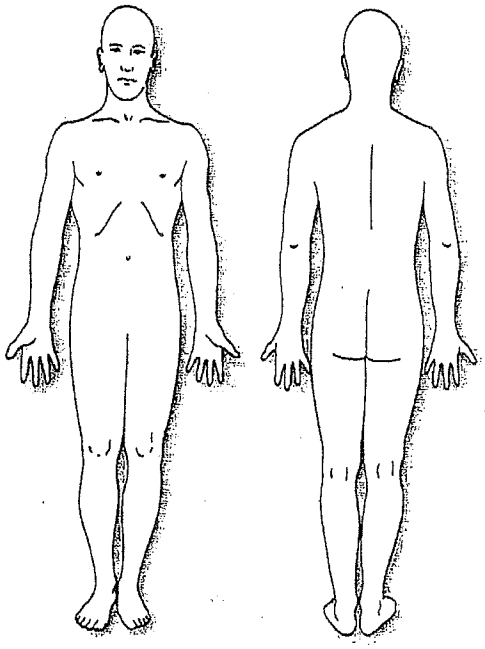
C. Electric D. Hot/Burning

E. Numbness F. Tingling

G. Cramping H. Tightness

I. Localized J. Radiating

Other: _____



My symptoms currently are:
Constant Come & go

Overall my symptoms are:
Improving Worsening
Not changing

My symptoms are made worse by:	**My symptoms are made better by:**
Walking/Activity	Rest
Sleeping	Activity
Sitting	Standing
Standing	Lying Down
Work Duties	Sitting
Turning/Twisting	Heat
Reaching	Cold
Bending	Medication
Gripping/Grasp	Massage
Stress	Brace/Assistive Device

Since the onset of your symptoms, have you had (circle all that apply)?

Unusual fatigue	Fever/Chills	Nausea/Vomiting	Waking pain at night
Dizziness/Fainting	Unusual Weight loss/gain	Diarrhea	Other

Please list your three (3) primary goals for therapy:

1._____ **2.**_____ **3.**_____

In case of unforeseen circumstance, please attempt to notify La Posada Outpatient Therapies department 24 hours in advance. Repeated cancellations or not showing up for scheduled therapy sessions may result in discontinuation of services. It is the department's policy that three late/cancellations/no shows within a thirty day period may result in your discharge from therapy. If you do not present to the clinic for three consecutive, scheduled visits without notification, you will be discharged back to the care of your physician.

I have read, understand, and agree to the above stated policy. _____ Date: _____

Patient/Guardian Signature

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Financial Policy

Thank you for choosing La Posada Outpatient Therapies for your therapy needs. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy that we require you to read and sign prior to any treatment.

REGARDING INSURANCE

We will gladly contact your insurance company to verify benefits and eligibility for therapy (i.e. number of visits available, authorization requirements and deductible and co-insurance amounts). The verification of benefits is not a guarantee that your insurance will provide 100% coverage. It is ultimately your responsibility to know your policy guidelines, limitations and exclusions which include co-payments, co-insurance and deductibles. If your policy requires a referral, failure to present this prior to services rendered may result in a loss of benefits. If you need assistance in obtaining this referral please contact our front office.

The patient or responsible party is responsible for the co-payment or co-insurance in the event that there is no supplemental insurance and in the event that the co-payment is denied by the supplemental insurance.

Your contract for health insurance is between you and your insurance company. We are not a party to that contract. It is ultimately your responsibility to see that your therapy bill is paid in full. Any remaining money unpaid by your insurance company will be your responsibility to pay in a timely manner.

_____
Initial

YOUR PAYMENT RESPONSIBILITY

All co-pays are due prior to any treatment. If you do not have insurance and are not eligible for other program benefits, you are responsible for all charges at the time service is rendered. We accept payments by cash, check, MasterCard, Visa or money order. Please be advised there will be a $20 fee for returned checks. Payment plans can be established with our billing specialist.

_____
Initial

NO SHOWS/ CANCELLATIONS

Because we commonly have a waiting list, we request to have a cancelled appointment at least 24 hours in advance. Please help us serve you better by keeping scheduled appointments, or call us to cancel in a timely manner to allow another patient to have your scheduled time. **If you have a scheduled appointment and fail to contact our office to cancel or reschedule prior to your appointment time a $25.00 charge will be assessed to your account.**

_____
Initial

Thank you for understanding our financial policies. If you have concerns or questions please feel free to ask our front desk receptionists or billing specialist.

I have read the Financial Policy. I understand and agree to this Financial Policy.

_____

Signature of Patient or Responsible Party Date