RED CANYON PHYSICAL THERAPY

PATIENT HISTORY FORM

Patient Name: _____ Age: _____ Today's Date: _____

History of Injury/Symptoms _____

Primary complaint/Reason for attending PT: _____

Date of injury or problem begin? _____ Date of Surgery? _____

What caused your problem to begin (select one of the following: Wear and Tear Car accident Work injury Sports injury

Other _____

Have you had any other treatment for this condition? _____

Have you ever had PT before? Yes ☐ No ☐ If "Yes" when was last time you had PT? _____

What tests have been done? X-ray ☐ MRI ☐ CAT Scan ☐ EMG ☐ Bone Scan ☐ Nerve Conduction ☐

Test Result(s): _____

Current Medication: _____

Check any other medical conditions you now have or have had in the past. (Select all that apply)

☐ Diabetes	☐ Kidney Disease	☐ Seizures	☐ Arthritis
☐ High Blood	☐ Liver Disease	☐ Nervous Disorders	☐ Anemia
☐ Heart Disease	☐ Headaches	☐ Depression	☐ Dizziness/Fainting
☐ Cancer	☐ Stroke	☐ Currently Pregnant	☐ Fractures
☐ Heart Attack	☐ Osteoporosis	☐ Thyroid Disease	☐ Hepatitis/HIV

Other: _____

Allergies(please list): _____

Recent surgery or hospitalizations? (please list): _____

Do you have a pacemaker or any metal Implants? Yes ☐ No ☐

Pain Level: Mark on the scale what level your pain is:

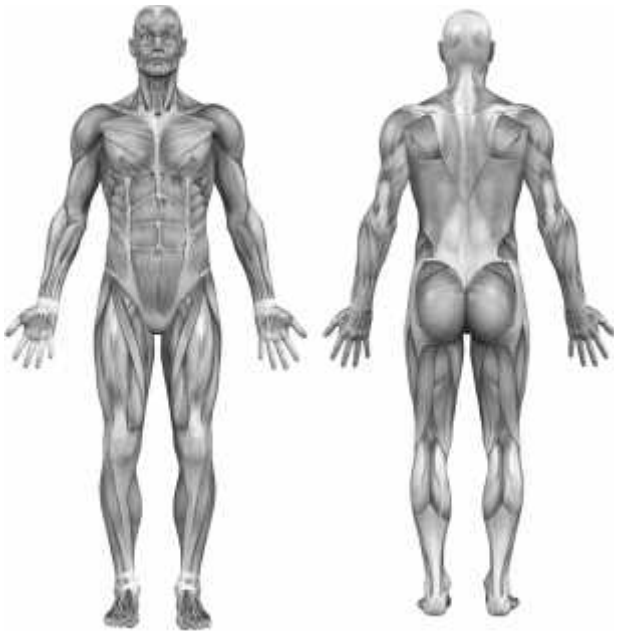
At its WORST: _____

At its BEST: _____

Is the pain: Constant ☐ intermittent ☐

Is your Condition: Improving ☐ Getting Worse ☐ Not Changing ☐

Where is your pain? Circle on the drawings below the areas where you feel your pain:



SIGNATURE OF PATIENT: _____

REVIEWED BY PT: _____

RED CANYON
PHYSICAL THERAPY

PATIENT HISTORY FORM

Patient Name: _____ Date: _____

Please Initial

Consent to Treatment: I consent to rehabilitation and related services at Red Canyon, LLC. In doing so, I understand, acknowledge and affirm that such rehab and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature.

_____

Cancellation Policy: If I cancel or do not show for an appointment within 24 hours of the appointment date, I understand that I may be charged a $25 fee.

_____

Treatment of Minors: I, as parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premise during any such treatment, and waive any claim I may have resulting from failure to do so.

_____

Liability: I know and agree that Red Canyon, LLC is not responsible for less or damage to personal valuables.

_____

Waiver and Release: I hereby release, discharge, and acquit Red Canyon, LLC, its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind a rising out of or resulting from my refusal to accept, receive, or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician, or urgent care services.

_____

Authorization of Payment: I hereby assign all benefits directly to Red Canyon, LLC and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice Of Privacy Practices.

_____

Notice of Privacy: I acknowledge receipt of the Notice of Privacy Practices.

_____

Benefit Information: Upon your first visit to the office, you will sign a benefits information sheet based on the most current information provided to us. Per the insurance is claimer, this information is not a guarantee of payment and subject to all applicable policy restrictions. Should this information be misquoted, we cannot be held liable. If you wish to call your carrier to verify your benefits our staff can provide you with assistance.

_____

Exceeding Authorization: Certain carriers have restriction and limitations on Physical Therapy services. Therefore it *is* the patient's responsibility to ensure these restrictions are not exceeded. Should these restrictions be exceeded patients will be granted the self-pay courtesy rate per our current policy.

_____

I certify that all the above information provided is true and correct. I hereby, authorize and instruct my insurance carrier to pay Red Canyon, LLC directly for any physical therapy services performed. Additionally, I understand that I am financially responsible for payment of all co-pays, deductibles and balances not covered by my insurance carrier, provided my specific plan does normally pay for the services and/or products rendered to me by the medical providers at this facility. In the event an outstanding balance is referred to an attorney for collection, I will be responsible for all costs of collection to include but not limited to litigation expenses, court costs, service of process fees and attorney's fees not to exceed twenty(20%) percent of the outstanding balance. I also waive the right to claim statue of limitations as a defense in any collection action and that any outstanding balance may accrue interest at a rate of eighteen(18%) percent per annum.

Patient/Guardian Signature: _____ Witness Signature: _____