

## Patient History Form

Patient Name \_\_\_\_\_ Age \_\_\_\_\_ Today's Date \_\_\_\_\_

### History of injury / symptoms

Primary complaint/Reason for attending PT \_\_\_\_\_

How were you referred/did you hear about RCPT? \_\_\_\_\_

Date of injury or problem begin? \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Surgery? \_\_\_\_/\_\_\_\_/\_\_\_\_

What caused your problem to begin? 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\_\_

Results of Tests? \_\_\_\_\_

Current Medication(s) taking \_\_\_\_\_

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

Diabetes	___	Kidney Disease	___	Seizures	___	Arthritis	___
High Blood Pressure	___	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 surgeries or hospitalizations? (please list) \_\_\_\_\_

Do you have a pacemaker or any metal implants? \_\_\_\_\_

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

At its **WORST:**

0 1 2 3 4 5 6 7 8 9 10  
 No pain \_\_\_\_\_ Makes you stop what you are doing \_\_\_\_\_ Worst pain  
 Need to go to E.R.

At its **BEST:**

0 1 2 3 4 5 6 7 8 9 10  
 No pain \_\_\_\_\_ Makes you stop what you are doing \_\_\_\_\_ Worst pain  
 Need to go to E.R.

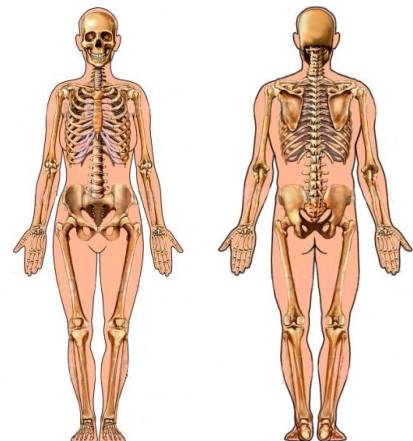
Is the Pain:  Constant  Intermittent

Is your Condition:  Improving  Getting Worse  Not Changing

SIGNATURE OF PATIENT: \_\_\_\_\_

REVIEWED BY PT: \_\_\_\_\_

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





**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 loss 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 arising 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 disclaimer, 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 statute 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** \_\_\_\_\_