

3124 N Swan Rd.
Tucson, AZ 85712
Phone (520) 325-4002
Fax (520) 325-4227
www.bodycentralpt.net

BODYCENTRAL
Physical Therapy
Sports & Wellness Center

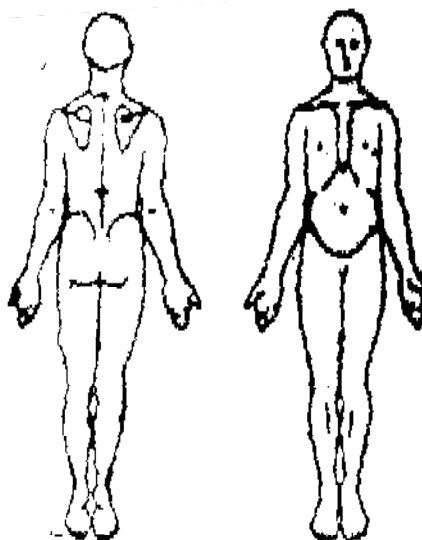
8327 N Oracle Rd.
Tucson, AZ 85704
Phone (520) 742-1865
Fax (520) 742-1632
www.bodycentralpt.net

Please fill out the following questionnaire as completely as possible. This enables your Physical Therapist to establish a clinical profile upon which a safe and appropriate therapy program is planned. Your input is very important. If you do not understand a question, your therapist will assist you. Thank you.

Name: _____ Occupation: _____
Leisure Activities/Hobbies: _____

Where is your pain? Using the following symbols, please mark on the drawing the areas where you feel pain.

Symbols: Pain (circle area)
Numbness ///////////////
Pins/needles :::::::::::::::
Shooting pain ↓



What does the pain feel like? (aching, sharp, burning, etc.)

Date of onset: _____

If this is an injury, please check the appropriate boxes and describe how it happened.

Motor Vehicle Accident Work Injury Sports Other

On a scale of 0-10 with zero (0) being "no pain" or "pain free" and ten (10) as the "worst pain" you can imagine, rate: The best it has been ____ The worst it has been ____ Your pain today ____

What makes your pain symptoms better? _____

Have you had this problem before? Yes No

Have you ever been diagnosed as having any of the following conditions?

Yes/No	Cancer, If YES describe what kind: _____		
Yes/No	Heart Problems	Yes/No	Pacemaker
Yes/No	Circulation problems	Yes /No	High blood pressure
Yes/No	Diabetes	Yes /No	Asthma
Yes/No	Osteoporosis	Yes/No	Hepatitis
Yes/No	Emphysema/Bronchitis	Yes/No	Thyroid problems
Yes/No	Tuberculosis	Yes /No	Latex sensitivity/allergies
Yes/No	Stroke	Yes/No	Multiple sclerosis
Yes/No	Kidney disease	Yes /No	Rheumatoid arthritis
Yes/No	Anemia	Yes/No	Other arthritic conditions
Yes /No	Epilepsy/seizures	Yes/No	HIV/AIDS
Yes/No	Sexually transmitted disease	Yes/No	Pregnant EDC: _____
Yes/No	Smoker	HT _____	WT _____

OB/GYN History: (female only)

Yes/No	Vaginal deliveries # ____	Yes/No	Vaginal dryness
Yes/No	C-Sections # ____	Yes/No	Painful periods
Yes/No	Episiotomy # ____	Yes/No	Menopause - When? ____
Yes/No	Prolapse or organ falling out	Yes/No	Pelvic Pain
Yes/No	Painful vaginal penetration		

Bladder/Bowel:

Yes/No	Trouble initiating urine stream	Yes/No	Recurrent bladder infections
Yes/No	Trouble feeling bowel/urge/fullness	Yes/No	Difficulty stopping urine stream
Yes/No	Constant dripping of urine	Yes/No	Dribbling after urination
Yes /No	Constipation/straining for movement	Yes/No	Childhood bladder problems
Yes/No	Trouble holding back gas/feces	Yes/No	Straining/pushing to empty bladder
Yes/No	Urinary hesitancy/slow stream	Yes/No	Blood in urine
Yes/No	Trouble emptying bladder completely	Yes/No	Trouble feeling bladder urge/fullness

Please list any surgeries or other conditions for which you have been hospitalized, list reason and approximate date:

Date:	Surgery/hospitalization:	Reason:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Which of the following OVER THE COUNTER medications/supplements have you taken in the last week?

Yes	No	Aspirin	Yes	No	Advil/Motrin/Ibuprofen
Yes	No	Tylenol	Yes	No	Laxatives
Yes	No	Vitamins/mineral supplement			

Please list any PRESCRIPTION medication(s) you are currently taking (including pills, injections, and/or skin patches):

Medication:	Reason:
_____	_____
_____	_____
_____	_____

CONDITIONS & CONSENT FOR PHYSICAL THERAPY

1. COOPERATION WITH TREATMENT:

I understand that in order for physical therapy to be effective. I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I understand that I may be discharged from physical therapy if I do not keep two (2) appointments without calling to cancel or reschedule.

I agree to cooperate with the home program assigned to me. If I have difficulty, I will discuss it with my therapist.

2. NO WARRANTY:

BODYCENTRAL Physical Therapy does not promise a cure for my condition. The staff will share with me the available statistics and studies regarding results, of physical therapy treatment for my condition. They will discuss all treatment options with me.

3. INFORMED CONSENT TO TREATMENT:

The term “informed consent” means that the potential risks, benefits and alternatives of physical therapy treatment have been explained to you. BODYCENTRAL Physical Therapy provides a wide scope of services and you will receive information at the initial visit on the treatment/assessment options available for your condition.

Potential Risks:

You may experience an increase in your current level of pain or discomfort or an aggravation of your existing injury. This discomfort is usually temporary and will probably subside in 24 hours.

Potential Benefits:

Benefits include an improvement in your symptoms and an increase in your ability to perform your daily activities. You may experience increased strength, awareness, flexibility and endurance in your movements. You may experience decreased pain and discomfort. You will have greater knowledge on managing your condition and the resources available to you.

Alternatives:

All physical therapy treatment options available for your conditions will be explained to you. You may inquire on the cost of these services and discuss them with your therapist. If you do not wish to participate in the therapy program, you may discuss your medical, surgical or pharmacological alternatives with your physician.

I have read or had read to me the foregoing and any questions, which may have occurred to me, have been answered to my satisfaction. I understand the risks, benefits and alternatives of the treatment. Based on the information I have received from the therapist, I voluntarily consent to physical therapy treatment. I understand that I may withdraw at any time.

Patient's Signature/Date

Therapist's Signature/Date

Patient's Guardian/Parent/POA

Relationship to Patient

To Our Patient's Regarding Appointment Scheduling

We all dislike long waits for our healthcare professionals and we are trying our best to stay on time to avoid making you wait for your appointment. Part of our efforts to do this includes you. Please make every attempt to be on time to your appointments. If you are late, it puts us behind...then we take the next patient late, then the next and so on. Some days we may run a little late for you because of this, and we apologize in advance. We understand traffic is a problem sometimes, sometimes it's hard to get kids moving in the morning, etc... we all have these things too, and we will do our best to see you even if you are a little behind schedule.

Following is our policy regarding appointments:

If you show up for your appointment only a few minutes past, we will probably still see you, but call us to make sure. Some days it is easier to fit you in than others. The final decision rests with your Therapist as he or she knows the schedule best.

If you are running really late (more than 10 minutes or so), we will probably reschedule your appointment, but call us—we still might be able to see you, see you at another time, or get you in with another therapist so you don't lose your appointment for the day.

I have read the above statements: _____

Patient Signature/Date

To Our Patients Regarding Cancellations and No-Shows

The following are our policies regarding cancellations and no-shows. We take this subject seriously at the clinic because it can make the difference between whether you succeed in treatment or not. Usually your doctor and/or therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your therapist's instruction and we will be able to help you achieve your goals in treatment.

- We require 24 hours notice in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible.
- There is a \$10 charge for cancellation without proper notice. This charge will not be covered by insurance, but will have to be paid by you personally. There is a \$20 charge for a no-show. This fee must be paid prior to beginning the next treatment session.
- Please understand that your pain will probably increase and decrease as your course of treatment progresses before it is finally released. Either condition can seem to be a reason not to come in: A) You're feeling worse and think the treatment is not working, or B) You're feeling better and it's a great day to go hiking in Sabino Canyon. Neither of these is a reason not to come: A) If you're in pain, come in and get it fixed, B) If you're out of pain, now's the time that we can begin doing some real correction of the underlying causes of your problem, educate you so you won't re-injure yourself, etc.
- When a patient doesn't show as scheduled, three people are hurt: the patient himself or herself because they don't get the treatment they need; the therapist who now has a space in their schedule since the time was reserved personally for that patient; and the patient who could have been scheduled for treatment if there had been proper notice.

Please cooperate with us in this regard and we will have you out of pain and back to full function quickly. We are looking forward to working with you.

Patient Signature

Date

Interviewer Signature

Date

Please read and sign below:

I hereby authorize BODYCENTRAL Physical Therapy to release my records to my physician listed above and my insurance carrier to obtain payment for services that shall be rendered.

I hereby authorize payment directly to the business office of BODYCENTRAL Physical Therapy, if any, otherwise payable to me for services.

Co-payments/Coinsurance payments are due at the time services are rendered. Any exceptions must be made prior to appointments with the therapist or authorized officer personnel.

I understand that I am responsible for the charges not covered by the above insurers, and for any missed scheduled appointments that are not cancelled 24 hours prior to the appointment time. To the extent permitted by Arizona statute, I agree, in the event of nonpayment to assume the costs of interest, collection and legal action. (***)Missed appointments are NOT covered by any insurance, and will be the responsibility of the patient at the rate of \$20).

I hereby authorize my insurance carrier to release information regarding my coverage to BODYCENTRAL Physical Therapy, P.C.. I also authorize agents of any hospital, treatment center, or previous physician to furnish copies of any records of my medical history, services or treatments.

I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services given by BODYCENTRAL Physical Therapy, P.C. In the event my insurance carrier does not accept Assignment of benefits, or if payments are made directly to me or my representative, I will endorse such payments to BODYCENTRAL Physical Therapy, P.C..

This agreement/consent will remain in effect unless revoked by me in writing, and signed by myself and an authorized representative from BODYCENTRAL Physical Therapy, P.C..

I have read the above statements and accept the terms. A duplicate of this statement is considered the same as the original.

Patient Signature/Date

Witness/Date

ACKNOWLEDGEMENT OF RECEIVING PRIVACY POLICY NOTICES

I _____ have been informed of and given access to a copy of the
“Notices of Privacy Policies” for **BODYCENTRAL Physical Therapy**.

Signature: _____

Date: _____

Witness/Date: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE REVIEW IT CAREFULLY.

HOW WILL WE USE AND DISCLOSE YOUR INFORMATION?

Treatment. Your health information may be used by BODYCENTRAL staff members or disclosed to other health care providers for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, after an evaluation with your physical therapist, the therapist may send a copy of that evaluation to your referring physician. That information may also be disclosed to people that assist with your care, a spouse, or legal guardian.

Payment. Your health information may be used to obtain payment for the medical services provided to you. For example, your health plan may request to see parts of your record before they will pay us for your treatment.

Health Care Operations. Your health information may be used as necessary to conduct day to day operations regarding budget planning and management activities. For example, your health information may be used to perform quality assurance activities at BODYCENTRAL Physical Therapy, or to develop marketing strategies for the practice. This information may be disclosed to any of the provider networks in which we participate for quality assurance and billing purposes as well.

Law Enforcement/Government Audits. Your health information may be disclosed to law enforcement agencies to support government audits and inspections and to facilitate law enforcement investigations. For example, if the Federal Government (Medicare) requests information, your information may be disclosed at that time.

Appointment Reminders. We may want to call you by phone at your home or office to remind you of appointments with us. If you do not wish us to leave a message with someone at your home, on your answering machine, or with a co-worker at your place of employment, please advise us of this.

Other Uses. Any other use or disclosure of your health information requires your written authorization.

WHAT ARE YOUR INDIVIDUAL RIGHTS?

You have certain rights under the federal privacy standards. These include:

Communications. You can request that our practice communicate with you about your health and related issues in a particular manner, or at a certain location. For example, you may ask that we talk to you while you are at home rather than when you are at work. We will accommodate reasonable requests.

You can request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. You also have the right to restrict disclosure of your health information to only certain individuals involved in your care or payment of your care, such as family members or friends. We are not required to agree to your request, however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you.

You have a right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records. You must submit your request in writing to BODYCENTRAL Physical Therapy, P.C..

You may ask us to amend your health information if you feel it is incorrect or incomplete, as long as the information is kept by or for our practice. To request an amendment, your request must be submitted in writing to BODYCENTRAL Physical Therapy, P.C.. You must provide us with a reason that supports your request for amendment.

You have a right to a list of disclosures we make of your medical information subject to federal privacy requirements. However, information released in certain circumstances, such as disclosures for payment, or treatment will not be included in the list.

You have a right to a copy of this notice. You may at any time request a copy of this document from us.

BODYCENTRAL Physical Therapy, P. C. Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We are also required to abide by the policies and procedures outlined in this notice.

RIGHT TO REVISE PRIVACY PRACTICES

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently

revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that request to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our privacy official- Jennifer Allen. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

COMPLAINTS

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter to:

Jennifer Allen, P.T. Privacy Officer
BODYCENTRAL P.T.
3124 N SWAN ROAD
TUCSON, AZ 85712
(520) 325-4002

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

EFFECTIVE DATE

This notice is effective on or after April 14, 2003