WELCOME TO CANYON VIEW PHYSICAL THERAPY

We genuinely appreciate your business. Our goal is to provide you with the highest quality of service and care available.

OFFICE POLICIES:

-**Attendance:** Please make every effort to attend your scheduled appointment. Consistent attendance is critical to your improvement.

-No Show/Cancellations: When you schedule an appointment, we set aside enough time for the therapist to provide you with the highest quality care. If you cancel an appointment without 24 hour notice, your therapist is unable to fill your time slot with another patient. For this reason, a **$50.00 fee** will be billed to you, not your insurance company, for failing to cancel an Initial Evaluation 24 hours in advance, or for an Initial Evaluation marked as a No Show. For each additional No Show, a **$25.00 fee** will be billed to you. Fees must be paid prior to rescheduling. If you No Show more than 3 appointments during your course of treatment, we reserve the right to discontinue further treatment. If you've been injured at work, your therapy is an ongoing part of your responsibility to your employer. If you cancel, no show, or are chronically late for therapy, we may be required to contact your employer and/or physician. We do realize circumstances can change at the last minute. If you were unable to attend a scheduled appointment due to extenuating circumstances, please contact our Office Manager. We may consider waiving the No Show fee.

-Co-Payments: Co-payments are due at the time of service.

HIPAA NOTICE OF PRIVACY PRACTICES

Our pledge regarding health information:

We understand that health information about you and your health care is personal. We are committed to protecting your health information. This notice applies to all of the records of your care generated by all staff in this health care practice.

We are required by law to:

-Make sure health information that identifies you is kept private.

-Give you this notice of our legal duties and privacy practices with respect to your health information.

-Follow the terms of the notice currently in effect.

Healthcare information can only be disclosed for the following: treatment, payment or health care operations. As required, we will disclose health information about you when required to do so by federal, state, or local law.

I have received the Notice of Privacy Practices from Canyon View Physical Therapy and understand my privacy rights related to them. I have also been offered the opportunity to review a comprehensive summary of my privacy rights under HIPAA.

_____ _____

Patient or Responsible Person's Signature Date Signed

_____ _____

Patient's Printed Name/or Adult signing for Minor Patient's Date of Birth

CONSENT FOR TREATMENT

The undersigned hereby consents to physical therapy procedures that may be rendered, as ordered by my physician. I understand that my care is under the supervision of my attending physician, his or her assistants or designees, and that Canyon View Physical Therapy (CVPT) is not liable for any act or omission of treatment, when following the instructions of that physician.

CONSENT FOR RELEASE OF HEALTH CARE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

As part of my health care, this organization originates and maintains health records describing my health history, symptoms, examination, test results, diagnosis, treatment and any plans for future care or treatment. Review of this health care record serves as:

-A basis for planning my care and treatment

-A means of communication among the healthcare professionals who contribute to my care

-A source of information for applying diagnostic and medical/surgical services to my bill for the purposes of reimbursement

-A means by which a third-party payer can verify that services billed were actually provided

-A tool for routine health care operations, such as assessing quality and reviewing competencies of health care professionals and processes

FINANCIAL AGREEMENT

I hereby assign and authorize payment directly to Canyon View Physical Therapy for all physical therapy benefits otherwise payable to me, in an amount not to exceed the clinic's charges for its services. I understand that I am financially responsible to CVPT for any charges not paid under this assignment. Should legal action become necessary to collect this bill, I understand that I will be held responsible for collection expenses and that services ordered by my physician may be denied for payment by insurance carriers.

Certification of responsible party: The signature below certifies that the above statements have been read and that the patient (or person authorized by the patient as their agent), accepts their terms. It also certifies that the patient has been offered CVPT's privacy policy which further explains the uses and disclosures of the patient's healthcare information. This consent is subject to the patient's cancellation in writing at any time, except to the extent treatment has already been provided. This consent, unless revoked, shall expire in ninety (90) days.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Printed Name of Patient or Responsible Party Relationship if not Patient

Patient Information

Patient Name	Nickname	Date of Birth	Social Security #	Home Phone
Address	Cell Phone	Marital Status	Gender	Cell Phone Carrier
City, State, Zip Code	Referring Physician	Seeking therapy for	E-mail Address	
Occupation	Patient's Employer & Work Address			Employer Phone
Primary Care Physician	Emergency Contact's Name	Contact's Phone		Relationship to Patient

Guarantor Information *Must be filled out for minor* *(Under age 18)*

Guarantor Name	Date of Birth	Relationship to Patient	
Address	City, State, Zip Code	Home Phone	

Insurance Information

Primary Insurance Name	Policy #, WC or Auto Claim	Group Number	**Policyholder's Date of Birth**	**Relationship to Patient**
Policyholder's Name(if other than Patient)	Policyholder's Home Address			**Relationship to Patient**
Policyholder's address and phone (if PH is other than patient)			Policyholder's SSN	Co Pay Amount

Worker's Compensation Claim

Claim Number	Name of Insurance	**Date of Injury**
Is your condition the result of an accident or injury? If so, provide how, where & in which state the injury occurred		Case Manager /Name and Phone
If a work-related injury, employer name at time of injury		Have you had any physical therapy on this claim?

Other Pertinent Information

Have you had any Physical or Speech Therapy this year? Yes No If so, how many visits of PT____ & ST_____

Have you ever had any Occupational Therapy this year? Yes No If so, how many visits? _____

Are you receiving Home Health Services of any kind at this time? Yes No ***If yes, please inform receptionist at this time.***

Regarding Privacy: I have read a copy of CVPT's Privacy Policies (sign & date)_____ Please initial the following that are acceptable to you: CVPT staff may leave messages with a person at my home____ and/or on my voicemail/answering machine at home____, work ____ or cell phone____. CVPT can discuss my account or care with the following individual_____.

I give my consent for treatment, authorize the release of necessary information to insurance carriers & appropriate personnel, & request that my insurance carriers pay CVPT directly. If direct payment is not permitted, I request that payment be issued jointly to CVPT & myself and mailed directly to CVPT. I will endorse checks so CVPT may cash & apply to my account accordingly. I understand I am financially responsible for any and all charges incurred. In the event my account is referred to a debt collector, I understand I will be responsible for all costs incurred to collect the debt in addition to my account balance.

Patient/Guardian Signature: **Date:**

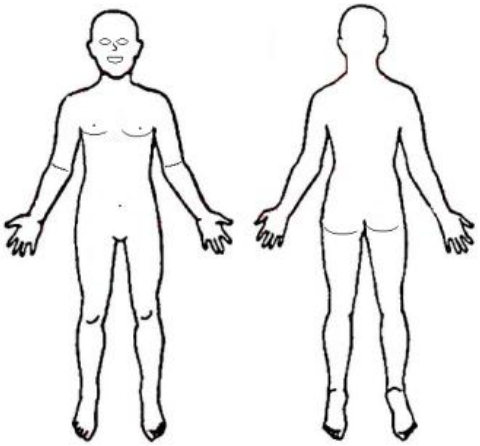
PATIENT INITIAL HEALTH QUESTIONAIRE

PATIENT NAME: _____ DATE: ____/____/____

1. Are you CURRENTLY being treated for other diagnosed medical problems? _____YES _____NO
   If yes, please elaborate: _____
2. Please circle any conditions that you HAVE or HAVE HAD in the past:

Diabetes	MS	Difficulty Urinating
Neuropathy	Pacemaker	Low Back Pain
Difficulty Walking	High Blood Pressure	Neck Pain
Circulatory Problems	Dizziness	Headaches
Seizers	Nausea	Osteoporosis
Asthma	Unexplained Weight Change	Cancer (Stable? ____YES ____NO)
Breathing Difficulties	Loss of Bladder or Bowles	

3. Do you have arthritis? ____YES ____NO If yes, what kind? _____
4. Do you have heart problems? ____YES ____NO
   If yes, please elaborate: _____
5. Are you currently pregnant? ____YES ____NO If so, when is your estimated due date? ____/____/____
6. Please list all current medications: _____
   _____
7. Please list all allergies: _____
8. What is your: Height: _____ Weight: _____
9. Have you fallen in the last 2 months? ____YES ____NO If yes, when? _____
10. Please list all previous surgeries: (Related or Unrelated) _____
11. Shade in or circle areas of pain or abnormal sensation:



Rate your pain at WORST and BEST:
(0=No Pain, 10=Emergency Room Pain)

0 1 2 3 4 5 6 7 8 9 10

12. Do you have any numbness or tingling? ____ YES ____NO
    If yes, please elaborate where: _____
13. What activities increase your symptoms? _____
14. What does your pain limit you from doing? _____
15. What decreases your symptoms? _____
16. When did your symptoms start? _____
17. What is your occupation? _____
18. Have you ever been treated for Physical or Occupational Therapy? ____YES ____NO
19. Is the problem you are being treated for involved in litigation? (lawsuit) ____YES ____NO
20. Are you suffering from depression or any other mental illness? ____YES ____NO If yes, have you sought medical care? ____YES ____NO Is it related to your current injury? ____YES ____NO
21. How did you hear about Canyon View Physical Therapy? _____