

AZHAR THERAPY & FITNESS

Patient Information Form



Patient Information

Name _____
Last First MI

Email _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Alternative/Cell Phone _____

Are you the primary card holder? Yes No

Male _____ Female _____

Date of Birth _____

Married _____ Single _____ Other _____

Place of Employment _____

Work Phone _____ Ext _____

SSN _____

Spouse / Parent Information

Name _____
Last First MI

SSN _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Alternative/Cell Phone _____

Relationship _____

Date of Birth _____

Place of Employment _____

Work Phone _____ Ext _____

Emergency Information

Name _____ Relationship _____

Address _____ City _____

Phone _____

State _____ Zip _____

Have You Had Physical Therapy This Current Year? Yes No

If Yes, Where _____ How Many Visits _____

Please read and initial each topic and sign the bottom of the form

Release of Medical Information

- I certify that the information given to Azhar Therapy & Fitness, Inc. in applying for payment is correct.
- I authorize the release of any medical information, by any other holder, to Azhar Therapy & Fitness, Inc.
- I authorize Azhar Therapy & Fitness, Inc. to release any physical therapy medical information required by any payer.
- I assign insurance benefits to Azhar Therapy & Fitness, Inc.

Initial

Responsibility of Payments

You are responsible for any co-payments at the time of service. Any deductibles on your policy will have to be paid at the time of service and payment plans can be arranged. If your insurance pays a percentage, we will delay billing you until your insurance reimburses for the dates. We will then bill you for the difference or you can make partial payments.

Initial

Documentation/Frequency of Visits

Documentation is a very integral part of our service. Your physician or physical therapist will prescribe a particular frequency and duration that will direct your care. The insurance companies require us to document every service we provide to you and they can deny service if our documentation doesn't support a definite medical concern. Your insurance company may request medical records for review at any time and make a review based on medical necessity. If inconsistencies in visits are documented without substantial reasoning, they can deny reimbursement. This will make you responsible for payment. Please keep this in mind when beginning your prescription.

Initial

Supplies

Your insurance company will most likely not reimburse for exercise equipment that is recommended despite the fact it supports your medical condition. Such supplies include: sensors, exercise tubing, therapy balls, home units, or other specialty items. Payments for supplies are due at the time of service and will be discussed with you if recommended or needed. This of course is your option.

Initial

SIGNATURE

DATE

AZHAR THERAPY & FITNESS

Medical History



Name _____
Last First MI

Date of Injury _____ Are you working now? _____

Have you had surgery for this injury? Yes No Date of Surgery _____

Are you currently taking any prescription or non-prescription medications? Yes No

Anti-inflammatory _____
Muscle Relaxants _____
Pain Medication _____
Other Medication _____

Have you had any of the following medical or rehabilitative services for this injury?

Chiropractor	<input type="checkbox"/> Yes <input type="checkbox"/> No	CT Scan	<input type="checkbox"/> Yes <input type="checkbox"/> No
General Practitioner	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emergency Room Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Neurologist	<input type="checkbox"/> Yes <input type="checkbox"/> No	EMG/NCV	<input type="checkbox"/> Yes <input type="checkbox"/> No
Occupational Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Myelogram	<input type="checkbox"/> Yes <input type="checkbox"/> No
Orthopedist	<input type="checkbox"/> Yes <input type="checkbox"/> No	MRI	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	X-Rays	<input type="checkbox"/> Yes <input type="checkbox"/> No

Other _____

Do you now have or have you ever had ANY of the following?

Alcohol problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular/ Rapid Heart Beat	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Replacement	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint/ Metal Implants	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Knee injury/ surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/ Swollen joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leg/ Ankle injury/ surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma, Bronchitis, or Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neck/ Back injury/ surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Clot/ Emboli	<input type="checkbox"/> Yes <input type="checkbox"/> No	Night Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer or Chemotherapy/ Radiation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Numbness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chills	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No
Coronary Heart Disease or Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Poor Circulation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression/ Nervousness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizziness/ Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shoulder injury/ surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Elbow/ Hand injury/ surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleeping problems/ difficulties	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy/ Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Smoking habit	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke/ TIA	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sweats	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Attack or Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid condition	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Urinating difficulty/ frequent	<input type="checkbox"/> Yes <input type="checkbox"/> No
High/ Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision/ Hearing difficulties	<input type="checkbox"/> Yes <input type="checkbox"/> No
Infectious Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight loss/ gain	<input type="checkbox"/> Yes <input type="checkbox"/> No

List any other information that would assist us in your care:

Are you aware of your diagnosis? Yes No _____

PATIENT or Responsible Party Signature

DATE

AZHAR THERAPY & FITNESS

Financial Policy



Dear Patient:

During the course of your treatment it is extremely important that you are compliant with all of your scheduled appointments to enhance your recovery and follow the treatment plan prescribed.

Cancelled appointments severely impact your treatment plan as well as prevent Azhar Therapy & Fitness from scheduling acutely ill patients who could have been seen that day, but were not because someone else was scheduled for that time spot. No shows also drive up the cost of patient care for everyone as staffing and overhead cost for services go unused.

Due to an increasing problem with patients missing scheduled appointments or “No Shows”; we regrettably must institute a “No Show Policy”.

A fee of \$35.00 will be collected on your visit following failure to show up for a scheduled appointment, or for cancellations with less than 24 hours notice.

This charge is not covered by insurance. We understand emergencies occur therefore rescheduling appointments is possible so please inform the front desk.

It is also important that you arrive on time for scheduled appointments to ensure the quality of your care as well as the quality of care for patients who do arrive on time for their appointments.

Patient care is of the utmost importance to the staff of Azhar Therapy & Fitness as evidenced by our past successes. We look forward to serving your needs.

I UNDERSTAND AND ACCEPT THE TERMS OF THE ABOVE OUTLINED APPOINTMENT POLICY AND WILL ABIDE BY THE STATED TERMS.

Printed Name

PATIENT or Responsible Party Signature

DATE

AZHAR THERAPY & FITNESS

Patient Essay



In your own words, please explain what you want to get out of your physical therapy. If you can, please explain it as it pertains to how you feel or function in your life. (Good examples are: pain, depression, restricted motion, any debilitations, energy level, weakness, or balance problems). Please feel free to write down anything that is bothering you. You should not be limited to those examples. We will take this information and make it our primary focus throughout your care. At the end of your care, we will have you complete a patient result form. This will be sent to your physician so that he/she is informed of your progress. This is like giving us a before and after picture. We would appreciate your cooperation in this matter.

Please state your comments below. Thank You!

SIGNATURE

DATE

AZHAR THERAPY & FITNESS

Acknowledgement of Receipt of HIPAA Notice



I, _____ have received the Notice of Privacy Practices
from the office of Azhar Therapy & Fitness, Inc.

Circle One

1. My medical care may be discussed with my spouse / children / significant other yes / no
2. Test results may be left on my answering machine/voice mail yes / no
3. Appointment information may be left on my answering machine yes / no

SIGNATURE

DATE

If Applicable

For personal representative of the patient

Print Name of Personal Representative _____

Describe Personal Representative Relationship _____
(Parent, guardian, etc)

Signature of Personal Representative

DATE

For Practice use only

Signature of Practice Employee _____ Date _____