ascension
PHYSICAL THERAPY
6200 Lake Otis Parkway Ste 104 ● Anchorage, AK 99507 ● P 907-770-6693 ● F 907-770-6697

CONSENT FOR TREATMENT

I hereby authorize Ascension Physical Therapy and/or staff to render whatever services are deemed necessary for my care or the care of my family.

Signature: _____ Date: _____

MEDICAL RELEASE & PAYMENT AUTHORIZATION

I hereby authorize Ascension Physical Therapy to release to my insurance carrier(s), any information necessary to process my medical claims. By signing this form, I am also authorizing my insurance carrier(s) to make payment directly to Ascension Physical Therapy.

Signature: _____ Date: _____

FINANCIAL AGREEMENT

I understand that if I wish for my insurance to be billed, I must provide complete and accurate information to Ascension Physical Therapy. I further understand that I am responsible for all fees incurred regardless of insurance coverage and that my insurance is being billed as a courtesy.

Signature: _____ Date: _____

CLINIC ETIQUETTE

- In order to provide the best care possible, we ask that you arrive for your scheduled appointment on time.
- We understand that on occasion, you may need to cancel your appointment with short notice due to unforeseen circumstances such as illness or emergency. However, we request a 12 hour cancellation notification, if possible, if you are unable to attend your scheduled appointment so we may offer your appointment time to another patient. After excessive cancellations and/or no shows, we reserve the right to discharge you from our clinic.
- As a courtesy to others, please turn your cell phone off while in the clinic.
- We are a drug, alcohol, and tobacco free facility. Please refrain from using any of these items while in the building.

Signature: _____ Date: _____

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6200 Lake Otis Pkwy, Suite 104, Anchorage, AK 99507 ph 907.770.6693 fx 907.770.6697

Name: _____ Age: _____

Gender: Male / Female Pregnant: Y / N Tobacco user: Y / N

Referring Physician: _____

Past Surgical History (list all & date): _____

_____

Please List All Current Medication: _____

_____

Have you had an X-ray, MRI, CT, Nerve Conduction Velocity (NCV), EMG, or Myelogram? (Please circle)

If yes, please explain findings: _____

Occupation: _____ Is an attorney involved in this case? Y / N

Past Medical History: Have you been told you have (or had?)

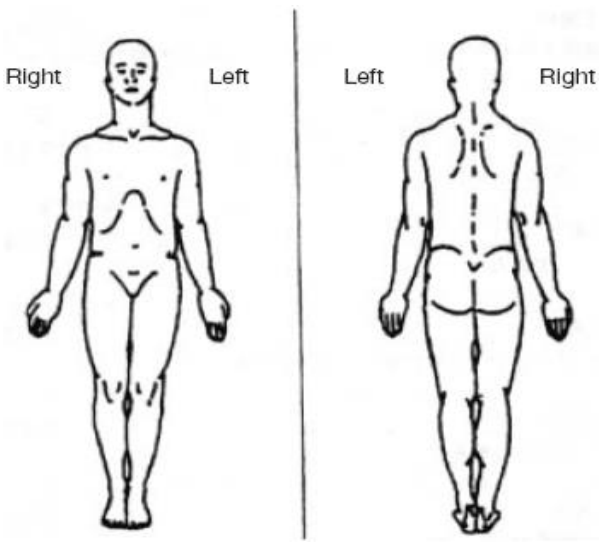
Cancer	Y N	Pace Maker	Y N	Lung Disease/ Pneumothorax	Y N
Diabetes Type 1 or II	Y N	DVT/ Blood Clot	Y N	Allergies/Asthma	Y N
Kidney Disease	Y N	Used Corticosteroids?	Y N	Seizures/Epilepsy	Y N
Liver Disease	Y N	Osteoporosis	Y N	Ulcers	Y N
Anemia	Y N	Gout	Y N	Hernia	Y N
Stroke/TIA	Y N	Osteoarthritis	Y N	Thyroid Disease	Y N
High Blood Pressure	Y N	Rheumatoid Arthritis	Y N	Joint Replacement	Y N
Heart Disease/ Heart Attack	Y N	Fibromyalgia	Y N	Recent Illness/Infection	Y N
Angina/ Chest Pain	Y N	Migraines or Headaches	Y N		

Are you currently experiencing?

Change in Health	Y N	Headaches	Y N
Unexplained Weight Changes	Y N	Poor Balance/Falls	Y N
Increased Pain at Night or Rest	Y N	Dizziness	Y N
Fevers/Chills/Night Sweats	Y N	Vision Difficulties	Y N
Weakness	Y N	Hearing Difficulties	Y N
Changes with Bowel/Bladder	Y N	Numbness/Tingling	Y N
Pain with Eating/Swallowing	Y N	Shortness of Breath	Y N
Difficulty Sleeping	Y N	Depression / Anxiety	Y N

Current Symptoms:

Why have you sought care today? _____
What date did your present pain begin? _____
How (gradual, suddenly, an injury)? _____
Have you received any prior treatment for this problem? Y / N _____
What are your goals for physical therapy? _____
Do you have any allergies? ☐ None ☐ Latex Please List: _____



Please circle the number that best represents your symptoms

Average, for the past 48 hours:
No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

Best, for the past 48 hours:
No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

Worst, for the past 48 hours:
No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

Please mark areas on the body where you feel your symptoms.

Do you have pain or concerns about your bowel, bladder, or sexually related activities/ functions? Y / N
Are you taking blood thinner? Y / N
Do you have abnormal bleeding tendencies? Y / N
Do you have any known diseases or infections that can be transmitted through bodily fluids? Y / N
Do you have any metal implants or other implants (i.e. breast, calf, joint hardware, etc.)? If yes, please list:

Aggravating Factors: Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem. List them below as 0 (unable to perform) to 10 (able to perform activity at same level as before your injury/or problem).

1) _____
2) _____
3) _____

Rate your ability 0-10
Rating: _____
Rating: _____
Rating: _____

HIPAA Privacy Standards
Ascension Physical Therapy

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.

Treatment Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations Your health information may be used as necessary to support the day-to-day activities and management of Ascension Physical Therapy. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.
Due to our office layout you may be receiving care while in the company of other patients. For example, exercising in the gym while other patients are present.

State & Federal Agencies Your health information may be disclosed to State & Federal agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department and other issues to law enforcement.

Other Uses and disclosures require your authorization Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

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

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information

- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Ascension Physical Therapy 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 privacy policies and practices that are 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 practice. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Jill Brekken.

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

Jill Brekken
Ascension Physical Therapy
6200 Lake Otis Parkway, Suite 104
Anchorage, AK 99507

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.

Contact Person The name and address of the person you can contact for further information concerning our privacy practices is the same as above.

Effective Date This Notice is effective on or after August 11, 2003.

Would you like a copy of this form? YES NO

Name:_____Date:_____

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Last Name: _____ First Name: _____ MI: _____
Gender: Male / Female
DOB: _____Marital Status: _____
Address: _____
_____
Home Phone #: _____ Cell #: _____
Email: _____
Social Security #: _____
Employer: _____Work Phone #: _____
Emergency Contact Name: _____Phone #: _____
Relationship to Patient: _____
How did you hear about us? _____
Reason for your visit: _____
Have you had Physical Therapy before? _____
Referring Physician: _____
Date of Injury/onset of pain: _____
Did you have surgery? _____If yes, what date? _____

Was your injury work **or** auto related? _____If yes, please provide the following:
Worker Comp: _____ **Auto Insurance**: _____
Employer Name: _____ Claim #: _____
Employer Address: _____ Name of insured: _____
Employer Phone #: _____ Is this your Auto policy? _____
Date of Injury: _____Date of accident: _____

Primary Insurance: _____ Relation to Patient: _____
Insurance ID #: _____ Group #: _____
Subscriber's Name: _____DOB: _____

Secondary Insurance: _____ Relation to Patient: _____
Insurance ID #: _____ Group #: _____
Subscriber's Name: _____DOB: _____