



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 require a minimum cancellation notice of no less than 2 hours prior to your scheduled appointment time if you are unable to attend your appointment so we may offer your appointment time to another patient. If you cancel within 2 hours of your appointment, we will consider it a no show and you will be assessed a \$35 No Show Fee. 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: \_\_\_\_\_ DOB: \_\_\_\_\_

Gender: M / F      Pregnant: Y / N      Tobacco: Y / N      Occupation: \_\_\_\_\_

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: \_\_\_\_\_

Have you been vaccinated for COVID-19? Y / N      Type: Moderna / Pfizer / Johnson & Johnson

Have you received a booster? Y / N      Date of last injection: \_\_\_\_\_

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

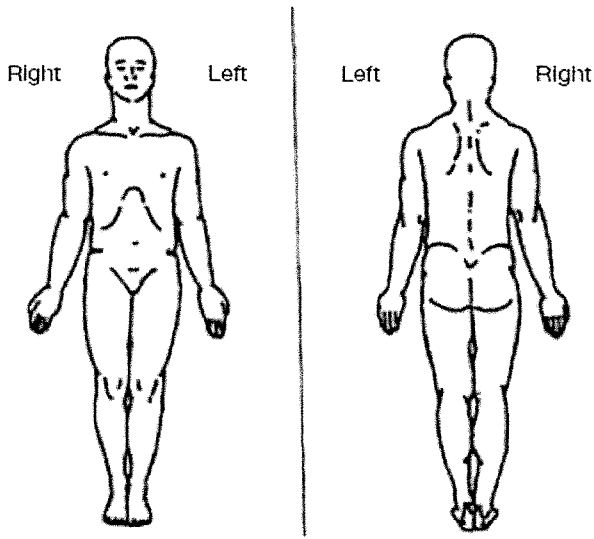
Cancer	Y N	Pace Maker	Y N	Lung Disease/Pneumothorax	Y N
Diabetes Type I or II	Y N	DVT/Blood Clot	Y N	Allergies/Asthma	Y N
Kidney Disease	Y N	Used Corticosteroids?	Y N	Seizures/Epilepsy	Y N
Liver Disease	Y N	Osteoporosis	Y N	Ulcers	Y N
Anemia	Y N	Gout	Y N	Hernia	Y N
Stroke/TIA	Y N	Osteoarthritis	Y N	Thyroid 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	Covid-19	Y N
MRSA	Y N	Tuberculosis	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.

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_

## 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: \_\_\_\_\_

## Ascension Physical Therapy Infection Control Policy

Our staff remains committed to ensuring the health and safety of everyone who walks through our doors. We are continuing to practice a high level of infection control and follow all guidelines from the Centers for Disease Control and Prevention to limit the exposure of any virus within our office. Please help us by participating in the following precautions:

- If you have any symptoms of illness please call and reschedule your appointment
- All patients and visitors will be required to wear a mask or facial covering to enter our facilities and while they are in the clinic. Masks or facial coverings are provided if you do not have one.
- We ask that you please wash your hands with soap and water or disinfect with hand sanitizer upon arrival.
- We will be practicing social distancing measures in our office as we are able, such as limiting handshakes and limiting the number of people in the waiting room.

### **COVID-19 SCREENING QUESTIONS**

1. **Have you been confirmed positive for COVID-19? \_\_\_\_\_**
2. **Are you currently experiencing, or have you recently experienced any symptoms such as fever, cough, shortness of breath, fatigue, muscle or body aches, headache, new loss of taste or smell, congestion or runny nose, nausea or diarrhea? \_\_\_\_\_**
3. **Have you knowingly been in close contact with anyone who has been confirmed positive for COVID-19? \_\_\_\_\_**
4. **Have you traveled out of state within the last 10 days? \_\_\_\_\_**

- If any of your answers to the COVID screening questions change at any time during your time as a patient at Ascension Physical Therapy please notify us immediately.
- If any of your answers to the COVID screening questions change within 48 hours of your PT visit please notify us immediately.

By signing this form, I have read and understand the information provided regarding infection control policies and COVID-19 screening and agree to comply with the above statements.

I understand that Ascension Physical Therapy has the right to reschedule my appointment if I answered yes to any of the questions on this form.

Signature of Patient (or person authorized to sign for patient):

\_\_\_\_\_ 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: \_\_\_\_\_