SEDONA PHYSICAL THERAPY, LLC dba LEBEC PHYSICAL THERAPY

Patient's Name: _____ Nickname: _____ DOB: _____

SS#: _____ email address: _____

Mailing Address: _____City: _____ State: ___ Zip _____

Primary Phone: _____ Secondary Phone: _____

Referring Provider: _____Primary Care Provider:_____

Emergency Contact: Name, Phone, Relationship: _____

Legal Guardian or POA: Name, Phone Relationship: _____

May we leave you phone messages? Y / N May we contact you via email? Y / N Via Text? Y / N

PLEASE READ AND SIGN THE FOLLOWING AUTHORIZATIONS:

AUTHORIZATION TO FILE INSURANCE CLAIM: I hereby authorize Sedona Physical Therapy, LLC to file my insurance claim on my behalf. I have provided current insurance cards and accurate insurance plan information.

ASSIGNMENT: I hereby assign therapy benefits otherwise payable to me to Sedona Physical Therapy. I understand and agree that there is no guarantee of reimbursement or payment from any insurance company or other payor. I am ultimately responsible for knowing and understanding the therapy benefit of my particular insurance plan I acknowledge full financial responsibility for, and agree to pay, any co-pays, deductible, co-insurances, balances, costs, fees and all charges.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize this therapist/clinic to release any information required in the course of my examination and treatment. I understand that this release will be limited to professional communications, compliance with insurance regulations, and the like as required in order to provide me with the best possible care, and that confidential medical information will be subject to the usual professional rules of clinician/patient privacy.

CONSENT FOR TREATMENT: I hereby give consent for examination and treatment by Sedona Physical Therapy. I am aware that Physical Therapy examination and treatment utilize hands-on techniques.

_____ (Initials) **CANCELLATION / NO SHOW POLICY:** I agree to give at least 24 hours' notice of cancellation. I understand that I will be charged $75 for a second and subsequent occurrences of a missed appointment or a cancellation with less than 24 hours' notice. I agree that after three "no shows" or cancellations with less than 24 hours' notice, I may be discharged from therapy.

I have read, understand and agree that all of the above information is true and correct.

Signed:_____ Date: _____

(Patient or patient's guardian/POA)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Sedona Physical Therapy, LLC
55 Southwest Drive, Sedona, AZ 86336
Phone: (928) 282-5050 Fax: (928) 282-5945

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from 3rd party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

A copy of our *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information is available upon your request. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: _____Date: _____

Patient/Guardian/POA Name_____ Relationship to Patient:_____

OFFICE USE ONLY: I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

MEDICARE PATIENTS

As of 2019, the former Medicare therapy caps are now annual thresholds that physical therapists are permitted to exceed for medically necessary services. For 2024, the threshold amount is for PT and SLP services combined. For services over $3000, a targeted medical review process kicks in. Should you and your therapist agree continued physical therapy is medically necessary, Sedona Physical Therapy may ask you to sign an Advanced Beneficiary Notice (ABN) agreeing to pay if Medicare does not, or later reverses their decision on audit.

If you are, or have been receiving HOME HEALTH CARE in any discipline, we must confirm that they have released you from their care **prior to treatment.** If you are currently receiving or have received outpatient physical therapy for any diagnosis you must notify us. Failure to notify us in advance of treatment may result in you being responsible for all charges.

Are you currently, or have you recently been receiving any type of home health service? Y N
Have you received any outpatient physical therapy or speech therapy services this year? Y N

I have read and understand the above statements:

Signature:_____Date:_____

Name: _____ DOB: _____ Date:_____

Name: _____ DOB: _____ Date:_____

MEDICAL INFORMATION Please Mark any of the following conditions that you have or had at one time:

- ☐ ARTHRITIS
- ☐ HIGH BLOOD PRESSURE
- ☐ HEART DISEASE
- ☐ EPILEPSY / SEIZURES
- ☐ MYOFASCIAL PAIN
- ☐ DIFFICULTY BREATHING
- ☐ CANCER
- ☐ MOTION SICKNESS
- ☐ FEVER / CHILL / SWEATS
- ☐ UNEXPLAINED WEIGHT LOSS
- ☐ BLOOD CLOTS
- ☐ HISTORY OF SMOKING
- ☐ DIABETES
- ☐ STROKE
- ☐ NERVOUS SYSTEM DISEASE
- ☐ HEAD INJURY
- ☐ OSTEOPOROSIS
- ☐ ANEMIA
- ☐ BLEEDING PROBLEMS
- ☐ HIV / HEPATITIS
- ☐ DEPRESSION
- ☐ ANXIETY
- ☐ OTHER:_____
- ☐ OTHER: _____

PREVIOUS SURGERIES:_____

_____

MEDICATIONS:_____

_____

ALLERGIES:_____

PRESENT SYMPTOMS:

What are we seeing you for today?_____

Specific date of start of symptoms? Where were you? _____

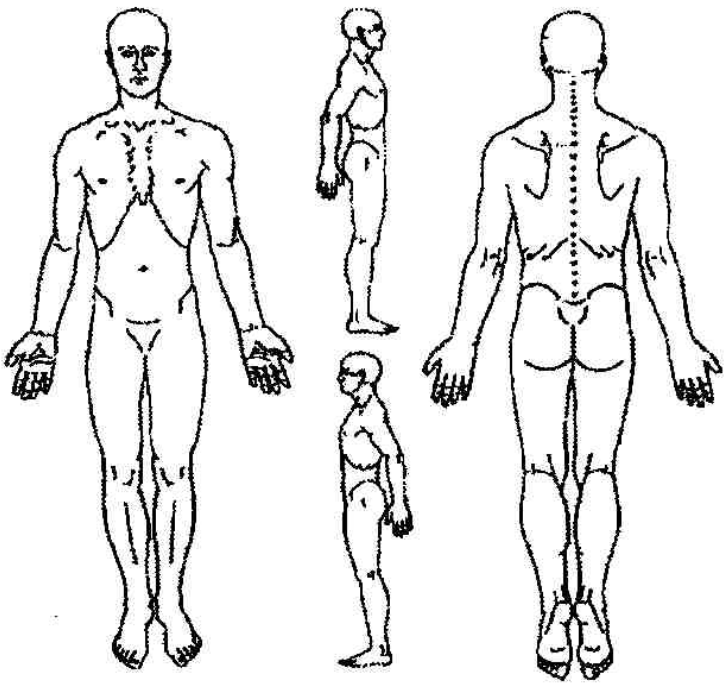
Previous treatments for this same condition? _____

List daily activities or goals that you would like to address during your physical therapy sessions: _____

_____

_____

Please mark areas of pain with “X”, numbness and tingling with “O”, and other symptoms with “S”



Please describe your pain:

_____

_____

_____

Please rank your symptoms on a scale of 0-10 (with 10 being most severe):

Today?_____

At worst this week? _____

At best this week? _____