

We are pleased to have you as a patient. You have been referred to physical therapy because your doctor believes you will benefit from our service. Research has shown that physical therapy can help to restore movement, relieve pain, strengthen muscles, improve over-all function and prevent further injury. We want to make your treatment at our facility as positive and effective as possible. We hope that your time here will be rewarding both physically and educationally.

FIRST VISIT: Our Physical Therapist will evaluate you to determine your specific physical needs in order to establish an individualized treatment program. This initial evaluation is usually no longer than 45 minutes to an hour, for aquatic evaluations usually 30 minutes (you will not be getting in the pool for the initial evaluation). You and your therapist will discuss and agree upon the goals of your treatment. A detailed summary of this evaluation will be mailed to your referring Physician.

TREATMENTS: The Physical Therapist may use methods such as therapeutic exercise, joint and soft tissue mobilization, ultrasound, electrical stimulation, heat/cold therapy and patient education. Most treatment sessions will last between 45 minutes to an hour.

HOME PROGRAM: During the course of your rehabilitation, your therapist will prescribe a home exercise program to be carried out on your own. This is an important part of your treatment program. In most cases, two to three hours a week spent in physical therapy is not enough time to improve function.

PROGRESS REPORTS: Your therapist will provide written updates on your progress to your referring physician before each of your follow-up visits with their office. ***It is essential that you inform our receptionist and your therapist of any return to physician dates you set so that we may prepare and present this progress report to your physician before your appointment.***

PAYMENT OPTIONS We accept checks, cash, VISA and MasterCard. We do not accept Discover or AMEX at this time.

CANCELLATIONS AND NO SHOWS AND TARDINESS: ***Same day cancellations and no shows will be subject to a \$25.00 charge.*** If you are more than 10 minutes late we may have to reschedule your appointment. Please call us as soon as you know your going to be late or not coming in. We have a 24 hour answering service so you can leave a message at any time.

DRESS: It is important that you dress appropriately for your treatment sessions. We recommend shorts/sweats, t-shirt and tennis shoes. For Aquatic Therapy bring your swimsuit water shoes/flip-flops, towel and a plastic bag to take home your wet items.

CHILDREN IN THE TREATMENT AREA: Children who are not being seen as patients will not be allowed in the treatment area, and are not to be left in the waiting area without adult supervision. This is for their safety as well as others.

FEES AND INSURANCE BILLING Your insurance is a contract between you and your insurance company. Professional services are rendered to you, not the insurance company. Almost every medical plan has a deductible amount and either a patient co-pay, patient co-insurance percentage, or both. Rarely is coverage 100%. It is good for you to call your insurance and verify your physical therapy coverage benefits we will also do this as well.

As a courtesy to you, we will bill your primary insurance company. It is your responsibility to furnish all necessary numbers and non-medical information regarding your insurance policy either prior or at the time of your appointment so that we can secure prior approval for physical therapy benefits. If we are unable to secure prior approval because we lack complete and correction information, all fees for service will be due from the patient at the time service is rendered. You will always be responsible to pay deductible amounts and to pay non-covered amounts on a weekly basis unless other arrangements have been made.

We appreciate your honest feedback regarding your experience with us. The greatest compliment you can give us is letting your doctor, friends and family know of your positive experience with us!

Therapists and Staff
Oakeson Physical Therapy

Name: _____ Date of Birth _____

Occupation: _____ Hobbies _____

Area of Pain: _____ Dominant: Right Handed Left Handed

Was there a injury? _____ Date of Injury: _____ How did the injury occur: _____

CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Neuromuscular	<input type="checkbox"/>	<input type="checkbox"/>	Fracture/Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/Blackouts	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Allergy to Latex	<input type="checkbox"/>	<input type="checkbox"/>	Headache/Migraine	<input type="checkbox"/>	<input type="checkbox"/>
Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/CVA	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots/Vascular	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Do you Smoke?	<input type="checkbox"/>	<input type="checkbox"/>	Bladder/Bowel Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Pace Maker	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____					

LIST MOST RECENT MAJOR SURGERIES:

Date: _____ Area: _____ Date: _____ Area: _____

Date: _____ Area: _____ Date: _____ Area: _____

ARE YOU CURRENTLY EXPERIENCING OR HAVE EXPERIENCED ANY OF THESE SYMPTOMS IN THE PAST 3 MONTHS?

- Fever
- Chills
- Bowel Dysfunction
- Shortness of Breath
- Numbness
- Vision Problems
- Hearing Loss
- Bladder Dysfunction
- Night Sweats
- Headaches
- Tingling
- Sharp Pains
- Increased Pain at Night
- Difficulty Sleeping
- Dizziness
- Pregnancy
- Excessive Weight Gain/Loss
- Other _____

HAVE YOU SOUGHT PREVIOUS TREATMENT, OR ARE YOU CURRENTLY RECEIVING OTHER CARE FOR THIS CONDITION?

- No other treatment
- Massage Therapy
- Chiropractor
- Physical/Occupational Therapy
- Psychiatrist/Psychologist
- Pain Management
- Other _____

HAVE YOU FALLEN MORE THAN ONCE IN THE PAST 12 MONTHS? IF YES, PLEASE SPECIFY:

USING THE PAIN SCALE 1-10 BELOW:

- 1) What is your **current level** of pain (1-10) _____
- 2) In the **past two weeks**, what has been your **least** level of pain (0-10) _____
- 3) In the **past two weeks**, what has been your **worst** level of pain (0-10) _____

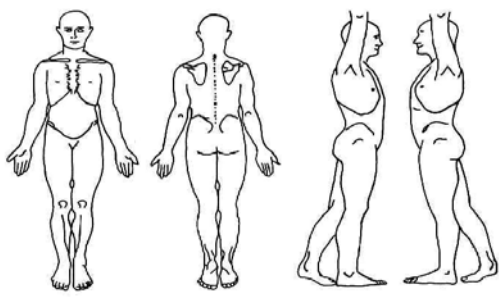
0	1	2	3	4	5	6	7	8	9	10
none		mild		moderate		severe				worst imaginable

Please mark with a "X" where your pain, numbness and or tingling is.

HEIGHT _____ WEIGHT _____

(OFFICE USE ONLY)
SCORE FORM: _____ NI BI DASH LEFS DHI BMI: _____

PLEASE COMPLETE MEDICATION LIST ON REVERSE SIDE →





CANCELLATION / NO SHOW POLICY

Due to the nature of physical therapy, your progress and full recovery are dependent on both our experienced physical therapists, and your active participation and commitment to your appointments. Our policy is as follows:

CANCELLATIONS:

If you need to cancel your appointment, please contact Oakeson Physical Therapy **at least one day prior to your appointment**. If you call to cancel your appointment on the same day as your appointment, a **\$25.00 Cancellation Fee** will be assessed. The fee will be due on your next scheduled date of service. An appointment rescheduled for the same day or within the same week is not considered a cancellation.

NO SHOWS:

If you have a scheduled appointment and do not show, a **\$25.00 No Show Fee** will be assessed. This fee can be **WAIVED** if you reschedule the missed appointment **WITHIN** the week that your appointment was scheduled.

VA Patients, AHCCCS Patients & Worker's Compensation Patients

We are required to report any missed or cancelled appointments to your case manager, primary care manager and insurance company. This could jeopardize your claim and or benefits, and prolong and or stop any benefits you may be entitled to. ***Excessive appointments missed may require us to put you on a same day scheduling status.***

Please **DO NOT CANCEL** if you are feeling worse and believe the treatment is not working. Keep your appointment and discuss any changes with your therapist. Please understand that your pain will probably fluctuate as your course of treatment progresses.

Please **DO NOT CANCEL** if you are feeling better. Keep your appointment in order to progress your plan and prepare for discharge.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. We understand that Special unavoidable circumstances may cause you to cancel. Fees in this instance may be waived but only with Provider approval.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. If you have any questions, please call our office at 623-878-9696.

Please sign that you have read, understand and agree to this Cancellation and No show Policy.

Printed Name

Signature

Date