Welcome to Oakeson Physical Therapy!

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

8240 W. Cactus Road • Peoria, AZ 85381 • (623)878-9696 • fax (623)776-0668 • www.oakesonpt.com
PATIENT REGISTRATION FORM

FIRST______________________________________________MI__________________LAST_______________________________________________________

☐ MALE  ☐ FEMALE  BIRTHDATE_________________________AGE__________________SOC SEC#______________________________

☐ SINGLE  ☐ MARRIED  ☐ DIVORCED  ☐ WIDOWED  ☐ OTHER  ☐ EMPLOYED  ☐ UNEMPLOYED  ☐ STUDENT  ☐ RETIRED  ☐ OTHER

ADDRESS: ________________________________STATE__________ZIP__________________________

CITY___________________________STATE______________________ZIP__________________

HOME#_________________________CELL#______________________E-Mail______________________________________________________

Emergency Contact: ________________________________Relation: ________________________________Contact Number: ________________________________

PATIENTS EMPLOYER:__________________________________________________________

ADDRESS:___________________________CITY___________________________STATE______________ZIP__________________________

PHONE:________________________________FAX:____________________________________

AUTHORIZATION TO TREAT: I hereby authorize the physical therapist, athletic trainers, therapy aides or other authorized medical personnel of Oakeson Physical Therapy to treat the above patient.

CANCELLATIONS/NO SHOW POLICY: There will be a $25.00 charge for a no-show or if the appointment is cancelled less than 24 hours prior to the scheduled time. We understand there will be emergencies and or situations where a phone call may not be possible, and we will handle those situations appropriately.

PRIVACY AND HEALTH INFORMATION: I acknowledge that I have had the opportunity to review a copy of Oakeson Physical Therapy’s Notice of Privacy Practices (“Notice”). I understand that I am responsible to read this Notice and notify OPT, in writing, of any request for restrictions in the use or disclosure of my PHI. I understand OPT has the right to revise this Notice at anytime and will post a copy of the current Notice in the office in a visible location at all times and on their website at www.oakesonpt.com. Oakeson Physical Therapy will provide me with a copy of its most recent Notice upon my request.

SIGN______________________________________________DATE_____________________

(Patient, parent or legal guardian of minor)
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: __________________________________________

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<thead>
<tr>
<th>CONDITION</th>
<th>YES</th>
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<td>Asthma</td>
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<td>Neuromuscular</td>
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<td>Fracture/Broken Bones</td>
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<td>Diabetes</td>
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<td>Arthritis</td>
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<td>Dizziness/Blackouts</td>
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<td>Heart Problems</td>
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<td>Allergy to Latex</td>
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<td>Headache/Migraine</td>
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<td>Lung Problems</td>
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<td>Stroke/CVA</td>
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<td>Blood Clots/Vascular</td>
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<td>Cancer</td>
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<td>Do you Smoke?</td>
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<td>Bladder/Bowel Disorder</td>
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<td>Pace Maker</td>
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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 ➔
## LIST OF CURRENT MEDICATIONS

**PRESCRIBED, INHALERS, OVER THE COUNTER AND HERBAL**

(Please include medication name, dosage, frequency and route.)

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dosage/Frequency</th>
<th>Reason for taking</th>
<th>Route (oral, inj. etc)</th>
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Allergies:________________________________________________________________________

_______________________________________________________________________________________________

Patient/Legal Guardian Signature _______________________________________________Date:_______________
APPOINTMENT CANCELLATION POLICY

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 24 hours in advance. Our office has a 24 hour message system to allow you to call at any time.

Our Physical Therapists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen.

We do allow one (freebie) same day cancel OR no-show per year... any after that a $25.00 fee will be assessed.

Thank you for being a valued patient and for your understanding and cooperation as we institute this policy. The policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

The Staff of Oakeson Physical Therapy.