HEIDEN ORTHOPEDICS

Patient Demographics

Legal First Name _____ Legal Last Name _____ Middle Initial _____ Birth Date ___/___/___

Billing Address _____ Apt. # _____ City _____ State _____ Zip _____

Main Phone # ___-___-___ type *(Circle One)*: Cell Home Work

Additional Phone # ___-___-___ type *(Circle One)*: Cell Home Work

Social Security # ___-___-___ Email Address _____

*Primary care physician _____ Race/Ethnicity _____

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ DP

☐ Male ☐ Female ☐ Transgender

Work Status: ☐ Working ☐ Unemployed ☐ Stay at home parent ☐ Retired ☐ Student ☐ Disabled_____

Employer: _____ Employer Phone: _____ Contact: _____

Emergency Contact Information

Contact Name _____ Contact Phone # ___-___-___ Relationship to Patient _____

Contact Address _____ Apt. # _____ City _____ State _____ Zip _____

Responsible Party (if under 18 years of age)

Responsible Party's Legal Name _____ Birth Date ___/___/___ Relationship to Patient _____

Responsible Party's Address _____ City _____ State Zip _____ Phone # ___-___-___

Insurance Information

Primary Insurance Company _____ Policy/Claim # _____ Group# *(If applicable)* _____ Effective date ___/___/___

Policy Holder's Name *(If not self)* _____ Policy Holder's Birth Date ___/___/___ Relationship to Patient _____

Secondary Insurance Company _____ Policy/Claim # _____ Group# (*If applicable)* _____ Effective date ___/___/___

Secondary Insurance Policy Holder's Name _____ Policy Holder's Birth Date ___/___/___ Relationship to Patient _____

Adjuster Name *(If workers compensation claim)* _____ Adjuster Phone # ___-___-___ Adjuster Fax ___-___-___

HEIDEN ORTHOPEDICS

Physical Therapy Informed Consent

At Heiden Orthopedics we are committed to providing you with the best possible physical therapy care. The following policies allow us to provide optimal care for all of our patients.

Physical therapy treatment is intended to result in improvement of your symptoms and an increase in your ability to perform daily activities. It is hoped that as a result of physical therapy treatment, that you may experience increased strength, flexibility, endurance and body awareness, in addition to decreased pain and discomfort.

Potential Risks & Limitations:
I understand that while it is expected that the physical therapy treatment I receive will be beneficial to me, there is a risk of harm involved in physical therapy treatment, and I accept such risk in the hope of obtaining beneficial results from such services. I understand that I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. No promises of any particular outcome or successful result have been made to me, and I understand that there is some uncertainty involved in the physical therapy services for which this consent is given.

Informed Consent to Physical Therapy Treatment:

I, _____, give consent to physical therapy services provided at Heiden Orthopedics to provide and perform physical therapy testing and services as deemed appropriate for my condition. I understand that there are no guarantees regarding a cure for or improvement in my condition. This consent applies to my initial visit and all subsequent visits. I understand that this consent may be revoked in writing at any time.

Other Care & My Responsibilities:
I understand that the physical therapy services I am requesting are one component of a range of healthcare choices. I also understand that I should discuss my condition with my primary care physician or specialist. I am responsible for the following: (1) to try to understand and follow instructions about my care and ask questions if I don't understand; (2) to provide correct and complete information about my health problems and medical history, including recent treatment and medications I may receive from other health care providers; and, (3) to accept responsibility for consequences following the decision to refuse treatment or instructions.

I have read and understand all the above terms. I understand the risks, benefits, and alternatives to treatment. Based on this information, I voluntarily consent to physical therapy treatment. I understand that I may discontinue treatment at anytime.

_____ _____
Patient's Signature (Or Patient's Legal Representative/Guardian/Parent) Date

Physical Therapy Financial Policy & Privacy Practices

In accordance with the Federal Truth in Lending Act, all physicians are required to give their patients information in connection with the extension of credit:

- **Basic Policy**: Patients are responsible for all medical bills resulting from services provided them by Heiden Orthopedics. It is the patient's responsibility to know their insurance contract benefits, assure collection of insurance payments and to resolve disputed claims with their insurance company.
- **Cancellation/No Show Policy:** **24 hours** notice of cancellation is required for any appointment. Any cancellations or no shows within 24 hours, will be assessed a **$50.00 fee** on the date of the appointment. Please notify our office as soon as possible of any cancellations.
- **Self Pay:** If the patient has chosen our Self Pay Policy, or patients insurance denies, or does not cover therapy at HO, they will be responsible for $125.00 at the time of sessions.
- **Insured Patients:** Please provide your identification card from your Primary and any Secondary Insurance to the receptionist at the time of your first visit. It is the patient's responsibility to contact their insurance company to determine benefits, or to answer questions regarding payments or denied claims. As a courtesy, Heiden Orthopedics will file primary insurance claims. If a dispute should arise between Heiden Orthopedics and the insurance company, it is the patient's responsibility to resolve the dispute, as the insurance policy is a contract between the patient and the insurer.
- **Returned Checks:** A handling charge of $20 will be charged for each returned check.
- **Acknowledgement of Privacy Practices:** I understand the email and/or phone number provided by me to Heiden Orthopedics may receive appointment reminders, updates about products and services, promotions, special offers, news & events. We will treat your data with respect and do not share your information with third party advertisers.
  The purpose of this Authorization and Release form is for your protection. The H.I.P.A.A. (Health Insurance Portability Accountability Act) of 1996 was created with the sole purpose and goal of protecting patient's medical records and financial information. We will not share this information without your consent. We urge you to complete this form to allow us to better serve and protect your private information. We appreciate your attention to this sensitive matter. Please be specific when designating your choices.

I (patient/parent/guardian) authorize the staff of Heiden Orthopedics to release any:

☐ FINANCIAL INFORMATION ☐ MEDICAL INFORMATION to the following people:

1. _____ 2. _____

Heiden Orthopedics will not release my medical information to individuals without a signed release form.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of my patient records.

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Private Insurance and all other health plans to Heiden Orthopedics. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered to be as valid as the original. By signing below, I agree to pay all amount(s) owed within 30 days of when such amount(s) are incurred. I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me. However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein. I agree that interest may accrue on all past-due amounts at the rate of 18% per annum (1.5% per month) until paid in full. In the event any amount(s) is/are referred to a third party debt collection agency, I agree that in addition to any other amount(s) allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc.) I will also be responsible for a collection fee of up to 40% of the principle amount(s) owing as allowed by Utah Code Annotated, sec. 12-1-11. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today. I hereby agree to the terms stated herein and authorize said assignee to release all information necessary to secure payment.

I have read and agree to the Financial Policy and Privacy Policy of this Office.

Print Name of Patient _____ **Date:** _____

Signature of Patient/Guardian: _____ **Date:** _____

Jan 2020

Physical Therapy Patient Information

Today's Date: _____

Name: _____ Birthdate: _____ Gender: _____

Address: _____

Email: _____ Phone: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Occupation: _____ Primary Care Physician: _____

Referring Physician (if you have one) or how you heard about us: _____

Reason for seeking physical therapy: _____

Have you had any tests completed for this condition (circle)? X-ray MRI Nerve tests Other _____

Are you currently being treated by a Chiropractor? _____

Desired Physical Activities & Exercise Participation: _____

_____

_____

Days per week you typically exercise: _____ For how long? _____

Are you able to fully participate in desired activities? YES☐ NO☐

What activities do you have **difficulty** doing (that you need to do or would like to do)? Exercise, cooking, cleaning, etc) _____

_____

_____

Medication list: _____

_____

What *goals* do you hope to accomplish with Physical Therapy? _____

_____

Rate the amount of your water intake: Excellent☐ Good☐ Fair☐ Poor☐

Rate the quality of your food intake: Excellent☐ Good☐ Fair☐ Poor☐

How many hours of sleep do you get a night? _____

Good quality sleep? Yes☐ No☐

During the past month have you been feeling down, depressed or hopeless? YES☐ NO☐
During the past month have you been bothered by having little interest or pleasure in doing things? YES☐ NO

Review of Systems	Check all that apply			
HEENT:	**GI:**	**CV:**	**MUSCULOSKELETAL:**	**HEMATOLOGY:**
☐ Difficulty Seeing	☐ Vomiting	☐ Irregular heartbeat	☐ Pain	☐ Anemia
☐ Eye Pain	☐ Diarrhea	☐ Heart murmur	☐ Stiffness	☐ Blood clot
☐ Change in Vision	☐ Bloody Stools	☐ Chest Pain on Exertion	☐ Back Pain	☐ Easy Bruising
☐ Ringing in Ears	☐ Constipation	☐ Pacemaker	☐ Diminished range of motion	☐ Easy Bleeding
☐ Hearing Loss	☐ Dark/tarry stools	**RESPIRATORY:**	☐ Swelling	**NEUROLOGY:**
☐ Sore throat	☐ Nausea	☐ Cough	**GU:**	☐ Headache
☐ Runny nose	**ENDOCRINE:**	☐ Pain with breathing	☐ Painful Urination	☐ Migraines
☐ Sinus Problems	☐ Intolerant to Heat	☐ Wheezing	☐ Bloody Urine	☐ Seizures
PSYCH:	☐ Intolerant to Cold	☐ Shortness of breath	☐ Urinate Frequently	☐ Stroke
☐ Depression	☐ Osteoporosis	**SKIN:**	☐ Awake at Night to Urinate	☐ Dizziness
☐ Anxiety	☐ Osteopenia	☐ Rash	☐ Incontinence	☐ Numbness
☐ Fatigue	☐ Excessive Thirst	☐ Lesions	**NECK:**	☐ Weakness
☐ Drug Addiction	☐ Excessive Hunger	☐ Lumps	☐ Neck or Thyroid Enlargement	☐ Concussion History? How many?
☐ Alcohol Addiction	☐ Unusual Weight Gain/Loss (circle)	☐ Sores ☐ Psoriasis	☐ Motor Vehicle Accident Hx	☐ Vertigo

Social History	
Tobacco Use? Yes ☐ No ☐ Packs per day _____ For how long _____ Type (cigarettes, vaping, chew, etc.) _____ Quit date _____	Alcohol Use? Yes ☐ No ☐ How many drinks per day _____ Type (beer, wine, liquor, etc.) _____ Quit date_____

General Medical History				
☐ Heart Disease	☐ Cancer/Tumor	☐ Asthma	☐ Ulcers	☐ GI Bleeding
☐ High Blood Pressure	☐ Diabetes- Type I or II	☐ HIV/AIDS	☐ Liver Disease	☐ Circulation Problems
☐ Heart Murmur	☐ Arthritis	☐ Hepatitis	☐ Kidney Disease	☐ Epilepsy
☐ Fibromyalgia	☐ Scoliosis	☐ Emphysema	☐ Thyroid Disorder	☐ Osteoporosis
☐ Bleeding Disorder	☐ Tuberculosis	☐ Stroke	☐ Hyperlipidemia (high cholesterol)	☐ Other
☐ Parkinson disease	☐ Multiple Sclerosis	☐ Head injury open/closed	☐ Meniere's Disease	☐ Other

Serious Illness not listed above? Yes ☐ No ☐ Illness type _____ For how long _____	Are you currently pregnant or breastfeeding? Breastfeeding? Yes ☐ No ☐ Pregnant? Yes ☐ No ☐ How far along? _____

Symptoms/Conditions in the last year				
☐ Chest pain	☐ Cough	☐ Dizziness	☐ Weakness in arms or legs	☐ Loss of balance
☐ Heart palpitations	☐ Shortness of breath	☐ Coordination problems	☐ Difficulty walking	☐ Falls? How many _____
☐ Joint pain or swelling	☐ Difficulty sleeping	☐ Loss of appetite	☐ Nausea/vomiting	☐ Bowel or bladder problems
☐ Fever/chills/sweats	☐ Headaches	☐ Hearing problems	☐ Vision problems	☐ High stress

Surgical History: (dates) and any additional medical history not stated above: _____

_____

_____

_____

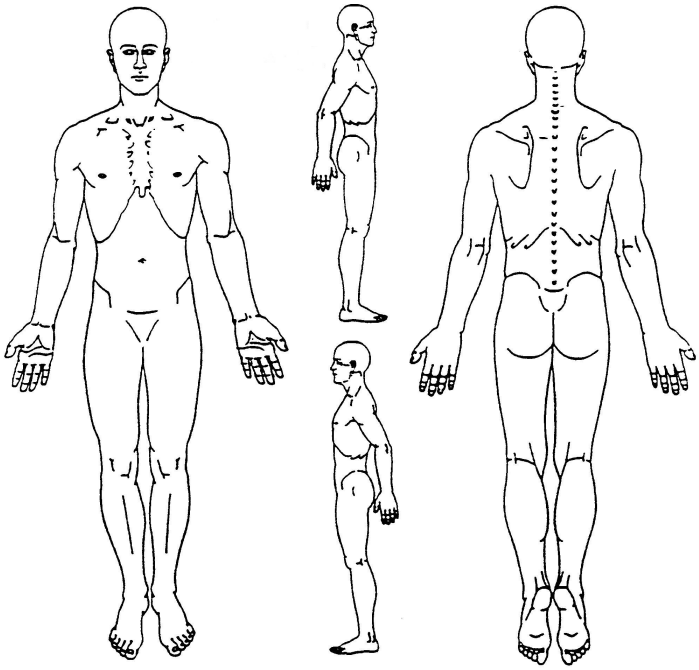
Pain:

Please rank your **current** pain 0-10 *(10 is the worst possible and requires emergency medical care)*

Today: _____ Best: _____ Worst:_____

Please mark on the body diagram the areas of your body where you are experiencing:

pain (XX), numbness (**), tingling (//), burning (##), stabbing (00), or dull ache (^^)



Signature (or Guardian):_____ Date:_____