REZAC & ASSOCIATES
PHYSICAL THERAPY, LLC
YOU make the CHOICE

855 Citadel Dr. E
Colorado Springs, CO 80909
Ph: (719) 465-1502
Fax: (719) 465-2087
rezacpt.com

Patient Registration

Grey Shaded Boxes Office Use Only

☐ ID Verified | Medical Record #

Date Completed:		Date Rx Received:		Date Scheduled:							
Name:	Last:		First:		MI:						
DOB:		SSN:		Email:							
Address:	Street:										
	City:		State:		Zip:						
Phone (Check Preferred):	☐ Home:		☐ Work:		☐ Cell:						
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed				Gender:	☐ Male ☐ Female					
Emergency Contact:					Phone:						
Parent (if minor child):					Phone:						
Responsible Party:					Phone:						
Address Responsible Party:	Street:										
	City:		State:		Zip:						
Work Status:	☐ Full-Time Employed ☐ Part-Time Employed ☐ Not Employed ☐ Retired ☐ Full Duty ☐ Light / Modified Duty ☐ No Duty / Medical Leave										
Job Title:		Employer:									
Was this a work injury?	☐ Yes ☐ No	If yes, skip insurance section, fill in workers compensation form									
Was this due to an accident?	☐ Yes ☐ No	If yes, is someone else responsible for payment?	☐ Yes ☐ No								
Do you have an attorney involved?	☐ Yes ☐ No	If yes to previous two questions, fill in accident / injury form									
Who Referred You to Us?	☐ Doctor ☐ Family / Friend ☐ Self (previous patient) ☐ Other Healthcare Professional ☐ Website ☐ Other										
	Name of Person Who Made Referral:										
Primary Insurance: ☐ Card Copied	Provider:				Policy #:						
	Policy Holder:				Eff. Date:						
	Phone:		Fax:		Contact:						
	Address:										
	Date Verified:		Deductible:		Met	☐ Yes ☐ No	Copay:				
	Comments:										
Secondary Insurance: ☐ Card Copied	Provider:				Policy #:						
	Policy Holder:				Eff. Date:						
	Phone:		Fax:		Contact:						
	Address:										
	Date Verified:		Deductible:		Met	☐ Yes ☐ No	Copay:				
	Comments:										
Tertiary Insurance: ☐ Card Copied	Provider:				Policy #:						
	Policy Holder:				Eff. Date:						
	Phone:		Fax:		Contact:						
	Address:										
	Date Verified:		Deductible:		Met	☐ Yes ☐ No	Copay:				
	Comments:										

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Original Date:		
Dates Revised:	**Date**	**Initial**

Patient Health History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*		☐ M ☐ F	**DOB:**	
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	**Height:**		**Weight:**
Referring Doctor:		**Primary Care Physician:**		
Other Healthcare Providers:				

PERSONAL HEALTH HISTORY

Check any conditions you have had:

Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio ☐ Birth Injury				
☐ Diabetes	☐ Osteoporosis	☐ Hyperthyroid	☐ Heart Disease	☐ Bowel Changes	☐ Vision Changes
☐ High Cholesterol	☐ Osteopenia	☐ Hypothyroid	☐ Pacemaker	☐ Bladder Changes	☐ Hearing Changes
☐ High Blood Pressure	☐ Arthritis (osteo)	☐ Asthma	☐ Cancer	☐ Vascular Disease	☐ Tinnitus / Ringing
☐ Low Blood Pressure	☐ Rheumatoid arthritis	☐ COPD	☐ Recent weight loss	☐ Difficulty Speaking	☐ Difficulty Swallowing
☐ Dizziness	☐ Head Injury	☐ Bronchitis	☐ Stroke / CVA / TIA	☐ Numbness/Tingling	☐ Depression
Women Only	☐ Pregnant	Number of Previous Births:	Number of C-Sections:	☐ Pelvic Pain	☐ Menstrual Pain

List any other medical problems including orthopedic injuries

Surgeries

Year	Reason	Surgeon or Hospital

Hospitalizations

Year	Reason	Hospital

Name *(Last, First, M.I.):*	**DOB:**

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies (drugs, environmental substances, activity induced, tape, latex):

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Health	How would you describe your general health?	☐ Poor	☐ Fair	☐ Good	☐ Excellent
	Are you generally happy with your overall health?	☐ Yes	☐ No		
	If no, what would you like to change?				

Name *(Last, First, M.I.):*					**DOB:**		
Weight	Are you happy with your current weight?				☐ Yes	☐ No	
	If no, what is your ideal weight?						
Diet	Are you dieting?				☐ Yes	☐ No	
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No	
	# of meals you eat in an average day?						
	Rank salt intake	☐ Hi	☐ Med	☐ Low			
	Rank fat intake	☐ Hi	☐ Med	☐ Low			
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola			
	# of cups/cans per day?						
Alcohol	Do you drink alcohol?				☐ Yes	☐ No	
	If yes, what kind?						
	How many drinks per week?						
Tobacco	Do you use tobacco?				☐ Yes	☐ No	
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	☐ # of years	☐ Or year quit					
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No	
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No	
Personal Safety	Do you live alone?				☐ Yes	☐ No	
	Do you have frequent falls?				☐ Yes	☐ No	
	Do you have vision or hearing loss?				☐ Yes	☐ No	
	Do you have any concerns about your personal safety?				☐ Yes	☐ No	

MENTAL HEALTH				
Is stress a major problem for you?	☐	Yes	☐	No
Do you feel depressed?	☐	Yes	☐	No
Do you panic when stressed?	☐	Yes	☐	No
Do you have problems with eating or your appetite?	☐	Yes	☐	No
Do you cry frequently?	☐	Yes	☐	No
Have you ever attempted suicide?	☐	Yes	☐	No
Have you ever seriously thought about hurting yourself?	☐	Yes	☐	No
Do you have trouble sleeping?	☐	Yes	☐	No
Have you ever been to a counselor?	☐	Yes	☐	No

I certify that the above history is true to the best of my knowledge:

Signature: _____ **Date:** _____
(check one) ☐ Patient ☐ Legal Guardian (minor child) ☐ Medical Power of Attorney (must provide proof)

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Patient Current Condition

Please answer the following in relation to the condition for which you are CURRENTLY coming to therapy
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Name: _____ **DOB:** _____

Condition Information

Primary Complaint: _____

_____

Diagnosis from your doctor: _____

Who referred you for this episode of care? _____

Has your doctor explained to you your diagnosis & prognosis? ☐ **Yes** ☐ **No**

Was this an injury? ☐ **Yes** ☐ **No** **Date of Injury or Symptom Onset:** _____

Describe injury or onset of symptoms: _____

_____

Any recent change in activity level or type (work, household, recreational)? ☐ **Yes** ☐ **No**

If yes, describe: _____

Since onset / injury, have your symptoms: ☐ **Improved** ☐ **Worsened** ☐ **No Change**

Have you had any surgeries for this condition or for this body part?

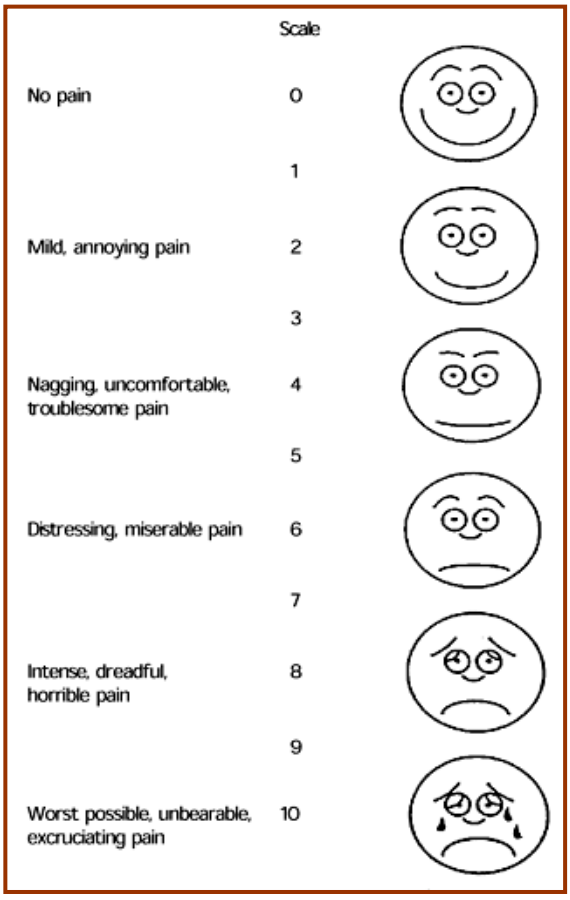
Type of Surgery	Surgeon	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any of the following for this condition? (Check all that apply)

	Outcome / Result	Dates
☐ **Physical Therapy**	_____	_____
☐ **Chiropractic**	_____	_____
☐ **Massage Therapy**	_____	_____
☐ **Acupuncture**	_____	_____
☐ **X-Ray**	_____	_____
☐ **MRI**	_____	_____
☐ **CT scan**	_____	_____
☐ **Bone Scan**	_____	_____
☐ **Nerve Conduction**	_____	_____
☐ **Other**	_____	_____

Pain Information

Rate your pain using the following scale: At Rest: _____ Best: _____ Worst: _____



What increases your pain? _____

_____

_____

What decreases your pain? _____

_____

_____

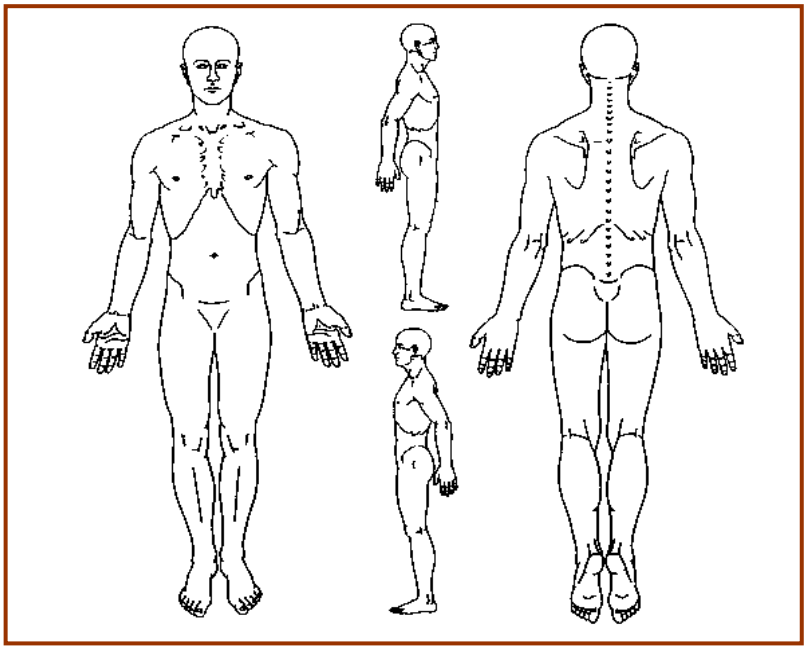
Describe your pain: _____

_____

_____

Indicate where you have symptoms on the diagram:

XX – Pain /// - Tingling or Burning ## - Numbness



Activity Information

What activities are you restricted from by your condition? (Check all that apply)

☐ Dressing	☐ Bathing	☐ Eating	☐ Driving	☐ Housework	☐ Sleeping
☐ Walking	☐ Lifting	☐ Sitting	☐ Standing	☐ Lying Down	☐ Recreational
☐ Pushing	☐ Pulling	☐ School	☐ Work	☐ Sports	☐ Yard Work

Please provide details of specific activities you are restricted from doing: _____

_____

_____

Patient Name: _____ DOB: _____

Work Information

I am currently: ☐ Employed Full Duty ☐ Employed with Restrictions ☐ On Medical Leave
☐ Not Employed AND ☐ Not Seeking Employment ☐ Seeking Employment

Job Title: _____
Duties: _____
Restrictions: _____

Physical Follow-Up

Next scheduled Doctor appointment(s):
Date _____ Physician _____
Date _____ Physician _____
Date _____ Physician _____

We are committed to a team approach to your care. Please inform your therapist whenever you have a scheduled appointment so we may send a progress note before your visit.

Physical Therapy Goals & Commitment

What do you WANT TO achieve from having therapy? Check all that apply:

☐ Improve home activities **☐ Improve mobility/walking activities**
☐ Improve leisure/sports activities **☐ Improve health/wellness**
☐ Improve self care activities **☐ Return to work/regular work duties**

What is your goal for therapy?

_____
_____

Please include any additional information you feel would help us provide your care
(I.e. any apprehensions about treatment, special communication, language, spiritual or cultural needs).

_____
_____
_____
_____

Will you have any problems attending therapy sessions? ☐ Yes ☐ No
If yes, please describe: _____
Will you have any problems performing a home program? ☐ Yes ☐ No
If yes, please describe: _____

I agree to be committed to my physical therapy program including attendance at scheduled visits and compliance with home program. I will inform my therapist if at any time I am unclear on my program or progress. I certify that the above history is true to the best of my knowledge:

Signature: _____ Date**:** _____
(Check one) ☐ Patient ☐ Legal Guardian (minor child) ☐ Medical Power of Attorney (must provide proof)

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Cancellation/Missed Appointment Policy

While we understand situations may arise that prevent you from making your scheduled appointment, please remember that your appointment time is valuable and has been specifically reserved for you. Last-minute cancellations and missed appointments are costly to our practice and take up appointment slots that could be offered to other patients waiting to get in. Therefore, out of respect for the physical therapists, staff, and other patients, we ask that you provide **24-hours notice** when cancelling or rescheduling an appointment. Failure to do so will result in a cancellation/missed appointment fee being applied to your account. This fee will **not** be covered by your insurance and is **your responsibility**.

FIRST APPOINTMENT – INITIAL EVALUATION

Due to the longer appointment time that is set aside to conduct the initial evaluation, failure to attend a first appointment or provider **24-hours notice** prior to cancelling may result in a **$50.00** cancellation/missed appointment fee. This fee must be paid in full prior to rescheduling.

SUBSEQUENT APPOINTMENTS

Following the initial evaluation, appointment cancellations require **24-hours notice** or a **$25.00** cancellation/missed appointment fee may apply. This amount will be collected at your next scheduled appointment, and if no future visits are scheduled, must be paid in full prior to scheduling. Since unplanned situations and unexpected emergencies do arise, two cancellation/missed appointment fees will be forgiven during your course of treatment.

If you arrive more than 15 minutes after your scheduled appointment and we cannot accommodate you, you will be rescheduled and charged a **$25.00** missed appointment fee. Every effort will be made to accommodate you, but we are a hands-on facility and need individual time with every patient. Whenever possible, please call to let us know you will be arriving late so that we can better plan our patient care and more easily accommodate you.

If you miss and/or cancel three appointments, we reserve the right to discharge you as a patient. A large part of the success of physical therapy is your participation. If you frequently cancel and do not show for appointments, your likelihood of improvement is significantly decreased. While we understand special circumstances, if it is a chronic issue we reserve the right to terminate your care at our facility.

I have read the above information and/or it has been explained to me and I accept the terms and conditions of the above and will be responsible for the payment of any fees my absence may result in.

Signature_____ Date_____

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Patient Privacy Policy & Procedure Statement

(HIPAA)

Dear Patient:

REZAC & ASSOCIATES PHYSICAL THERAPY maintains compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations passed into law on December 20, 2000.

We obtain your voluntary consent to provide treatment and release medical records to the appropriate entities, and those who you designate, to provide health care treatment, obtain payment, and conduct daily operations at the facility.

Our clinical and front office staff will use patient information to ensure quality care and appropriate billing for services.

You may correct, amend, access, and request a copy of your medical record and access history by signing a letter for release of your medical information. The cost for copies of medical records is in accordance with state law.

We protect all patient information within the guidelines provided by federal, state, and local government.

If you have any grievance pertaining to the privacy of medical records or wish to inquire further about how our facility manages patient information, please contact our Privacy Officer at (719)465-1502.

Rezac & Associates Physical Therapy reserves the right to amend, change, and or revise our privacy policy at any time in accordance with federal, state, and local rules, regulations, and guidelines.

Thank you for choosing Rezac & Associates Physical Therapy for your healthcare.

Signature_____ Date_____

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PHONE MESSAGE CONSENT

Rezac & Associates Physical Therapy, LLC PC will at times need to contact you. By filling out the information below we will be better able to serve.

In effort to protect you privacy, we have developed a policy on leaving medical care messages:

- We will ***NOT*** leave messages with anyone except the patient or legal guardian.
- We will ***NOT*** leave any confidential information on an answering machine.
- We will ***NOT*** leave any messages on a voicemail.

UNLESS
WE HAVE YOUR WRITTEN PERMISSION TO DO SO.

I, _____ give Rezac & Associates Physical Therapy, LLC PC my permission to speak with and/or leave phone messages regarding my medical care and/or billing with the following. I fully understand that this consent will remain valid until revoked in writing.

Preferred Phone Number(s): _____

Authorized Individuals: _____

Signature: _____ Date: _____

EMAIL REMINDERS/NEWSLETTER SIGN-UP

Rezac & Associates Physical Therapy, LLC PC has the ability to send reminders via email to remind you of the day and time of scheduled appointments. We also offer a monthly Health and Wellness video newsletter. If you would like to subscribe to either of these services, please check the appropriate box(es) below.

□ Add me to your Video Newsletter □ Add me to your Email Reminders

Email Address: _____

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Consent for Care and Treatment

I, Undersigned, do herby agree and give my consent for Rezac & Associates Physical Therapy to furnish medical care and treatment to_____ which is considered necessary and proper in the diagnosing or treating of my (their) physical condition.

Signature: _____ Date:_____

Benefit Assignment/ Release of Information

I, the undersigned, herby assign all medical benefits, i.e.: Medicare, private insurance, major medical benefits, Workers' Compensation and any other health plans to which I am entitled to Rezac & Associates Physical Therapy, LLC PC. A photocopy of this consignment is to be considered as valid as the original. I hereby authorize Rezac & Associates Physical Therapy, LLC PC to release all medical information and records necessary to secure payment for services rendered.

Signature: _____ Date:_____

Financial Policy Statement

It is our policy to bill your insurance carrier or other provider of medical benefits as a courtesy to you, although you are responsible for the entire bill when the service is rendered. Required co-payments and estimated co-insurances are to be made as services are rendered and arrangements are to be made for payment of all amounts not covered by you medical benefits as soon as those amounts are known. If your medical benefits are not paid within sixty (60) days, the balance will be due in full from you.

All co-insurance percentages paid at the time of service are estimated. Your actual liability may be more. You are responsible for any difference between the estimated and actual co-insurance due.

If any payments of medical benefits are made directly to you for services rendered by Rezac & Associates Physical Therapy, LLC PC, you must promptly remit such payment directly to Rezac & Associates Physical Therapy, LLC PC.

If you are a Workers' Compensation patient the above policy does not apply to you. Be advised, however, that you may be responsible for our charges if your Workers' Compensation claim is successfully controverted.

If you fail to make timely payment for any amount for which you are responsible, you will be responsible for all costs of collection, including court costs, collection agency fees, and/or a reasonable attorney fee.

I have read the above information and/or it has been explained to me and I accept the terms and conditions of the above and will be responsible for the payment of my account.

Signature: _____ Date:_____