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

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**		**Was this due to an accident?**		☐ **Yes** ☐ **No**		
If the accident was auto-related, what was the date of the accident & what state did it occur in?	**Date of Accident:**		**State of Accident:**				
Do you have an attorney involved?	☐ **Yes** ☐ **No**		**Attorney Name:**				
Who Referred You to Us?	☐ **Doctor** ☐ **Family / Friend** ☐ **Self (previous patient)** ☐ **Other Healthcare Professional** ☐ **Website** ☐ **Other**						
	Name of Person Who Made Referral:						
Primary Insurance:	**Provider:**				**Policy #:**		
	Policy Holder:				**Eff. Date:**		
	Phone:		**Fax:**				
	Address:						
Secondary Insurance:	**Provider:**				**Policy #:**		
	Policy Holder:				**Eff. Date:**		
	Phone:		**Fax:**				
	Address:						
Tertiary Insurance:	**Provider:**				**Policy #:**		
	Policy Holder:				**Eff. Date:**		
	Phone:		**Fax:**				
	Address:						

If you are a <u>Medicare</u> patient, are you <u>currently</u> receiving home health care?	☐ **Yes** ☐ **No**
If you are a <u>Medicare</u> patient, are you <u>currently</u> receiving physical therapy at any other location?	☐ **Yes** ☐ **No**
If you are a <u>Health First Colorado (CO Medicaid)</u> patient, are you <u>currently</u> receiving physical therapy at any other location?	☐ **Yes** ☐ **No**

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Patient Health History Questionnaire

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

PROVIDERS

Please check the box beside the provider's name if you would like us to share medical documentation with them.

Referring Doctor:	☐	**Primary Care Physician:**	☐

Other Healthcare Providers

☐	☐
☐	☐

PERSONAL HEALTH HISTORY

Height:		**Weight:**	

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/Hospitalizations

Year	Reason	Surgeon or Hospital

List your prescription medications, over-the-counter medications, and herbals/vitamins/nutritional supplements			
Name of Medication	**Dosage**	**Frequency Taken**	**Route of Administration (i.e. oral, topical, inhaled, etc)**

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?				
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

Over the last 2 weeks, how often have you been bothered by any of the following problems:	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h. Moving or speaking slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐
If you indicated any problems above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not at all ☐	Somewhat ☐	Very ☐	Extremely ☐

Is stress a major problem for you?	☐	Yes	☐	No
Do you panic when stressed?	☐	Yes	☐	No
Do you cry frequently?	☐	Yes	☐	No
Have you ever attempted suicide?	☐	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
All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

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?

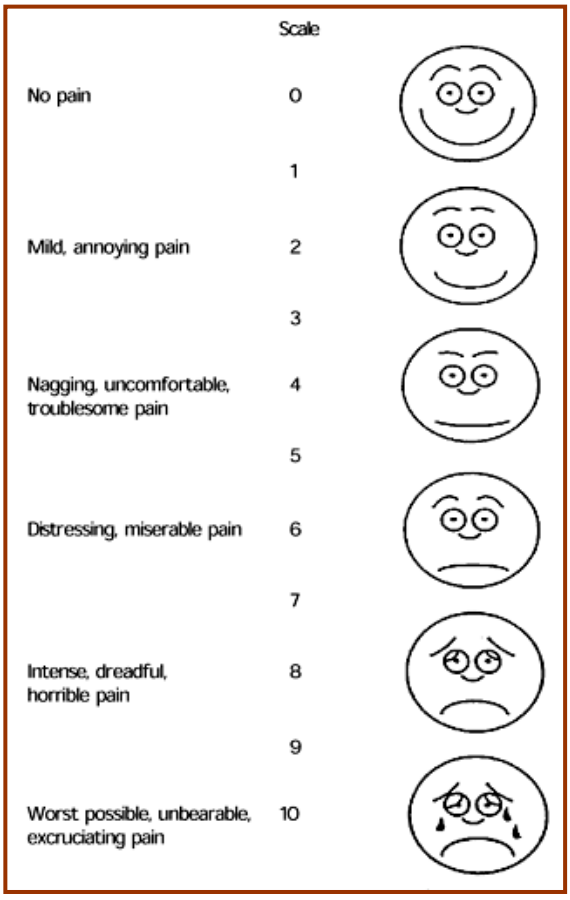
Type of Surgery	Surgeon	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

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? _____

_____

_____

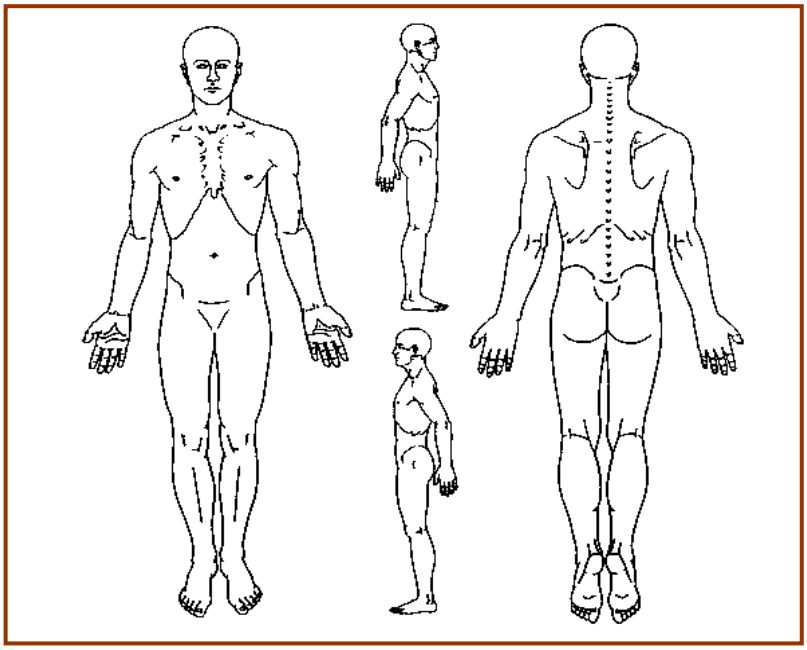
Describe your pain: _____

_____

_____

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.

For a cancellation or reschedule to count as 24-hours notice, we ask that if you have an AM appointment you contact our office in the AM the day before to cancel. If you have a PM appointment, please contact our office by 7PM the day before to cancel or reschedule. If you have a Monday appointment or an appointment that follows an office closure, we will accept cancellation requests left on our voicemail if they follow the same rules above.

Unlike many other medical offices, we elect not to charge cancellation fees. We recognize extenuating circumstances such as illness, weather, unplanned emergencies, etc. may arise, as those same circumstances affect our staff, and we may occasionally have to cancel your appointments without 24-hours notice too. However, if you miss and/or cancel or reschedule three appointments without 24-hours notice, we reserve the right to reduce the number of appointments you are allowed to schedule or terminate your care at our facility.

If you arrive late to a scheduled appointment and we cannot accommodate you, you will be rescheduled. 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 late arrivals become a chronic issue, we reserve the right to reduce the number of appointments you are allowed to schedule or terminate your care at our facility.

A large part of the success of physical therapy is your participation. If you frequently cancel, arrive late, 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 will evaluate whether physical therapy is appropriate for you at this time.

I have read the above information and/or it has been explained to me and I accept the terms and conditions of the above.

Signature _____ Date _____

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Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I reviewed a copy of this medical practice's Notice of Privacy Practices available at https://www.rezacpt.com/files/pdf/PRIVACYPRACTICES.pdf. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment if I request one.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient
☐ Guardian or conservator of an incompetent patient

Name of Patient: _____

Complete the following only if the Patient refuses to sign the Acknowledgment:

Patient Name: _____ DOB: _____ Account #: _____

Efforts to obtain: _____

_____

Reasons for refusal: _____

_____

Patient accepted the copy: ____ Patient declined a copy: _____

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

PHONE MESSAGE CONSENT

☐ I authorize Rezac & Associates Physical Therapy, PLLC to leave phone messages regarding my appointments, medical care and/or billing. My preferred phone number(s) are: _____
_____

☐ I authorize Rezac & Associates Physical Therapy, PLLC to discuss my appointments, medical care, and/or billing with following individuals (i.e. family members, caregivers, etc): _____
_____

EMAIL & TEXT MESSAGE APPOINTMENT REMINDER CONSENT

Rezac & Associates Physical Therapy, PLLC can send reminders via email and/or text message to remind you of the day and time of scheduled appointments. If you would like to receive appointment reminders, please select from the options below:

☐ I authorize Rezac & Associates Physical Therapy, PLLC to send me appointment reminders via email. My email is: _____.

☐ I authorize Rezac & Associates Physical Therapy, PLLC to send me appointment reminders via text message. I understand that standard text message rates from my wireless carrier may apply. My phone number is: _____.

NEWSLETTER SIGN-UP

Rezac & Associates Physical Therapy, PLLC offers a monthly Health and Wellness video newsletter. If you would like to subscribe, please check the box below.

☐ I authorize Rezac & Associates Physical Therapy, PLLC to add me to their Video Newsletter.
Email Address: _____

By signing below, I fully understand that the consents listed above will remain valid until revoked in writing.

Signature: _____ Date: _____

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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:_____