

**DESERT HAND & PHYSICAL THERAPY PATIENT DATA SHEET**

**First:** \_\_\_\_\_ **MI:** \_\_\_\_\_ **Last:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Gender:** Male  Female

**Physical Address:** \_\_\_\_\_ **Mailing Address:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

<b>Phone Numbers:</b>	<b>OK To Call</b>	<b>Best Time To Call</b>
Home: _____	<input type="checkbox"/>	_____
Work: _____	<input type="checkbox"/>	_____
Cell: _____	<input type="checkbox"/>	_____

**May we send you text messages for your appointment reminders to the number(s) listed above?**  Yes  No

**May we send you text messages for Marketing Materials, including Patient review requests to the number(s) listed above?**  Yes  No

**By marking "Yes" above, you understand that text messages may NOT be secure, with a risk of unauthorized access to your information**

**May we send you emails relating to your care with us?**  Yes  No  
**By providing your email address below, you understand that email communications may NOT be secure, with a risk of unauthorized access to your information.**  
**Email:** \_\_\_\_\_

**Preferred language:** \_\_\_\_\_ **Interpreter required?**  Yes

**Date of Injury:** \_\_\_\_\_ **Referring Physician:** \_\_\_\_\_  
**Injury Area:** \_\_\_\_\_ **Auto or Work Accident:**  Auto  Work  N/A

**State Where Accident Occured:** \_\_\_\_\_  
**Are you currently receiving or have you received Home Health Services (including any therapy, nursing, bathing & dressing, etc) in the last 60 days?**  Yes  No  
**Are you currently receiving or have you received other therapy services in the last 60 days?**  Yes  No

**Marital Status:**  
 Married  Single  Divorced  Widowed  Separated  Unknown

**Student Status:**  
 Full-Time  Part-Time  None

**EMPLOYMENT STATUS**

**Employment Status:**

Active Military    Full-Time    None    Part-Time    Retired    Self Employed

**Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**INSURANCE INFORMATION**

**Primary Insurance:** \_\_\_\_\_

**Policy Holder's Name:** \_\_\_\_\_ **Holder's Birth Date:** \_\_\_\_\_

**Policy or Certificate #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Policy Holder's Employer:** \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_

**Policy Holder's Name:** \_\_\_\_\_ **Holder's Birth Date:** \_\_\_\_\_

**Policy or Certificate #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Policy Holder's Employer:** \_\_\_\_\_

**How did you hear about us?**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Physician      | <input type="checkbox"/> Hospital               | <input type="checkbox"/> Marketing Ad - Print               |
| <input type="checkbox"/> Employer       | <input type="checkbox"/> Cross Referral         | <input type="checkbox"/> Marketing Ad - TV                  |
| <input type="checkbox"/> Case Manager   | <input type="checkbox"/> Friend - Word of Mouth | <input type="checkbox"/> Marketing Ad - Billboard           |
| <input type="checkbox"/> Former Patient | <input type="checkbox"/> Attorney               | <input type="checkbox"/> Marketing Ad - Direct Mail - Email |
| <input type="checkbox"/> Adjustor       | <input type="checkbox"/> Self                   | <input type="checkbox"/> Marketing Ad - Facebook            |
| <input type="checkbox"/> School         | <input type="checkbox"/> Screens - Open Houses  | <input type="checkbox"/> Marketing Ad - Other _____         |

Specify if other : \_\_\_\_\_

**Note: Please provide us with the most updated information below.**

**EMERGENCY AND OTHER CONTACTS**

Name	Phone	Work	Cell	Fax	Type

**DISCLOSURE OF MEDICAL RECORDS**

I authorize the following individuals to have access to my medical and billing records:

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

PATIENT INTAKE AND CONSENT FORM

Internal Use Only:    A/C#    Name    A/C Type    Office #

**CONSENT TO TREATMENT**

I consent to rehabilitation and related services at: DESERT HAND & PHYSICAL THERAPY In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature.

Initials: \_\_\_\_\_

**TREATMENT OF MINORS**

I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.

Initials: \_\_\_\_\_

**LIABILITY**

I know and agree that: DESERT HAND & PHYSICAL THERAPY is not responsible for loss or damage to personal valuables.

Initials: \_\_\_\_\_

**WAIVER AND RELEASE**

I hereby release, discharge and acquit: DESERT HAND & PHYSICAL THERAPY its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.

Initials: \_\_\_\_\_

**AUTHORIZATION OF PAYMENT**

I hereby assign all benefits directly to: DESERT HAND & PHYSICAL THERAPY I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice Of Privacy Practices.

Initials: \_\_\_\_\_

**FINANCIAL POLICY**

I understand fully that, in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

To assist in establishing your account, please:

- Supply all necessary information for accurate billing of your claim, including your insurance card, driver's license, employer information, and demographic information.
- Satisfy all insurance co-payments, co-insurance, deductibles, and non-covered services on the day services are rendered.
- Provide your insurance company and us with any additional information requested to complete the processing of claims filed on your behalf.

Initials: \_\_\_\_\_

**NOTICE OF PRIVACY/PATIENT BILL OF RIGHTS**

I acknowledge receipt of Notice of Privacy Practices.

Initials: \_\_\_\_\_

I acknowledge receipt of the Statement of Patient Rights.

Initials: \_\_\_\_\_

I certify that all of the information provided herein is true and correct.

Patient/Guardian  
 Signature \_\_\_\_\_

Witness  
 Signature \_\_\_\_\_

Date \_\_\_\_\_

## MEDICAL HISTORY

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of injury/ onset: \_\_\_\_\_ Date of surgery: \_\_\_\_\_

What side of the body are we treating today? **Right** **Left** **Both** **Other**

How did your injury happen? \_\_\_\_\_

Do you have any open cuts, lesions or wounds? Yes No If yes, where? \_\_\_\_\_

Accident Related? Auto \_\_\_ Work \_\_\_ Other \_\_\_ Are you Right or Left Handed? \_\_\_\_\_

Occupation: \_\_\_\_\_ Working \_\_\_\_\_ Off Work \_\_\_\_\_ Light Duty \_\_\_\_\_

Reason for attending therapy: (check all that apply): Motion \_\_\_ Weakness \_\_\_ Pain: 0 1 2 3 4 5 6 7 8 9 10

What specific activities are most difficult because of your problem?

1. \_\_\_\_\_ 2. \_\_\_\_\_

Do you use tobacco: (check one): Yes \_\_\_ No \_\_\_ If so how much? \_\_\_\_\_

### Current Medications -dosages and frequency (required for Medicare):

Name of Medication	Dosage	Amount	How Often
1			
2			
3			
4			
5			

Allergies: \_\_\_\_\_ Are you allergic to Latex? Yes \_\_\_ No \_\_\_

Wear glasses/contacts? YES \_\_\_ NO \_\_\_ Any previous injuries to this extremity? \_\_\_\_\_

Have you fallen in the past year? YES \_\_\_ NO \_\_\_ If Yes, How many times? \_\_\_\_\_

Did you sustain any injuries as a result of the fall? YES NO

### Have you ever had any of the following conditions? (Circle all that apply)

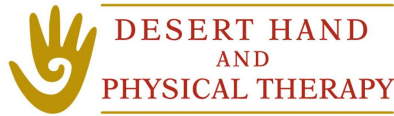
Anemia      Depression      Hepatitis      HIV      Currently Pregnant      Stroke      Asthma  
 Kidney Problems      Dizziness/Fainting      Tuberculosis      Cancer      Fractures      Epilepsy  
 Respiratory Problems      Substance abuse      Insomnia      Headaches      Diabetes      Seizures  
 Metal Implants      Pacemaker      Osteoporosis      Low Blood Pressure      High Blood Pressure  
 Cardiac problems      Rheumatoid Arthritis      Osteoarthritis      Thyroid Problems      Multiple Sclerosis

Any other medical problems? \_\_\_\_\_

### TREATMENT CONSENT

The nature of your treatment, the risks, the possible interventional alternatives and treatment goals have been discussed with you. Also, your medical history has been reviewed by the therapist to assist them in your evaluation and assessment. I agree that DH&PT may provide medical information regarding this injury to my primary care physician, in addition to my referring physician.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Therapists Initials \_\_\_\_\_



**DESERT HAND  
AND  
PHYSICAL THERAPY**

**CONSENT TO USE OF LIKENESS AND TESTIMONIAL AND RELEASE**

I, \_\_\_\_\_, hereby consent to allow Desert Hand and Physical Therapy and its employees, agents, partners, and affiliates (collectively “Clinic”), to use my name, photograph, videotape/audiotape recording, and/or written testimonial (“marketing materials”) in Clinic’s marketing brochures, publications, and/or on their website and social media accounts, including but not limited to Facebook and Twitter, to promote the services offered by Clinic. I understand and agree that these marketing materials are owned by Clinic and will not be returned to me.

I hereby release, hold harmless, and forever discharge the Clinic from any and all claims, demands, and causes of action which I have or may have by reason of this authorization.

Further, I hereby affirm that I have read this Consent to Likeness and Release, and I fully understand the content, meaning, and impact of this agreement. This agreement shall be binding upon me and my heirs, legal representatives and assigns.

\_\_\_\_\_  
Participant Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Legal Guardian (If Participant is a Minor)

**HIPAA AUTHORIZATION FOR DISCLOSURE OF PHI**

I, \_\_\_\_\_, hereby consent and authorize Desert Hand and Physical Therapy and its employees, agents, partners, and affiliates (collectively “Clinic”) to disclose my Protected Health Information (“PHI”), as that term is defined in the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), for marketing purposes, as stated below. I understand that subsequent disclosures by recipients of my PHI may not be protected by the HIPAA Privacy Rule or other applicable medical record privacy laws.

Further, I authorize Clinic to disclose my PHI, in the form of written statements, photographs, and videotape/audiotape recordings, for purposes of promoting and advertising Clinic’s services.

I understand that I may revoke this authorization at any time by giving written notice to Clinic, except to the extent that Clinic and its agents, employees, and representatives may have taken action in reliance on this authorization.

This authorization is effective on the date stated below for an indefinite period of time. A photocopy of this authorization form is valid and should be given the same force and effect as the original.

\_\_\_\_\_  
Participant Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Legal Guardian (If Participant is a Minor)