C.H.A.M.P
PHYSICAL THERAPY & PILATES
Creating Health and Movement for Performance

4340 W Chandler Blvd, Suite 3
Chandler, AZ 85226
P: 480-361-1127
F: 480-361-1842

Patient Registration

Today's Date: _____ Date of 1st Visit: _____ Diagnosis/Reason for Treatment: _____

Returning Patient? ☐ Yes ☐ No Payment Type: ☐ Self Pay ☐ Insurance ☐ Auto ☐ Workers Comp

Patient Name: _____ **Date of Birth**: _____

Street Address: _____ Apt/Unit: _____

City: _____ State: _____ Zip Code: _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Best Way to Contact: ☐ Cell Phone ☐ Home Phone ☐ Email

Emergency Contact Information

Emergency Contact Name: _____ Relation: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Physician Information

Referring Physician: _____ Office Phone: _____

Primary Care Physician: _____ Office Phone: _____

Have you had physical therapy before? ☐ Yes ☐ No If yes, when/where? _____

Insurance Information

Primary Insurance: _____

Member ID#: _____ Group #: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Relationship to Patient: _____ Subscriber Phone: _____

Subscriber Address (if different from patient): _____ Apt/Unit: _____

City: _____ State: _____ Zip Code: _____

Secondary Insurance: _____

Member ID#: _____ Group #: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Relationship to Patient: _____ Subscriber Phone: _____

Subscriber Address (if different from patient): _____ Apt/Unit: _____

City: _____ State: _____ Zip Code: _____

Auto & Workers Comp

Insurance: _____ **Claim #**: _____

Date of Injury: _____

Adjuster Name: _____ **Adjuster Phone**: _____

Adjuster Fax: _____ Adjuster Email: _____

Attorney Name: _____ Attorney Phone: _____

Attorney Address: _____ Suite/Unit: _____

City: _____ State: _____ Zip Code: _____

Attorney Phone: _____ Attorney Fax: _____

Attorney Email: _____

Employer Information *(For all Worker's Comp)*

Employer Name: _____ Employer Phone: _____

Employer Address: _____ Suite/Unit: _____

City: _____ State: _____ Zip Code: _____

Other

How did you hear about us? _____

If you are a returning patient, what brought you back to us? _____

Consent to Treatment

I hereby authorize the professional staff at C.H.A.M.P Physical Therapy & Pilates to examine and treat me with physical therapy for the injury I have been referred here for or referred myself to.

_____ _____
Patient Signature Date

_____ _____
Patient Printed Name Staff Witness Signature

_____ _____
Parent or Guardian Signature (if under 18) Date

_____ _____
Parent or Guardian Printed Name Staff Witness Signature

Assignment of Benefits and Release of Medical Information
Instruction for Direct Payment to Health Provider

Insurance Company/Companies Name(s) _____

I hereby instruct the above-named insurance company/companies to pay by check made out to and mailed directly to: C.H.A.M.P Physical Therapy & Pilates (Assignee) for professional or medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy.

I hereby release Assignee, its officers, agents, employees and any clinical staff associated with my case, from all liability that may arise as a result of disclosure of information to the above-named insurance company(s) or their designated representatives. By signing this Assignment of Benefits and Release of Medical Information I acknowledge the following: I am aware and understand that this authorization will not be used unless the above named insurance company(s) or their designated representatives request records of information for reimbursement purposes; or seek to take action reference payment for treatment services, I agree to participate and assist Assignee or its designated representatives with any appeal process necessary to collect payments for services rendered, I understand that this assignment and authorization is subject to revocation at any time except to the extent that action has been taken in reliance thereof, I understand Assignee is acting in filing for insurance benefits assigned to myself and it can assume no responsibility for guaranteeing payment of any charges from the insurance company(s), I understand a firm contracted by Assignee for billing and collection purposes may do billing, I understand that Assignee is appointed by me to act as my representative and on my behalf in any proceeding that may be necessary to seek payment from my insurance carrier which includes receiving a copy of my insurance plan's documents, I agree that should an overpayment take place, a refund check will be mailed to the authorized party that is due the overpayment, I agree that Assignee shall be entitled to the full amount of its charges without offset.

HIPAA REGULATIONS

I understand that C.H.A.M.P Physical Therapy & Pilates complies with HIPAA and will protect my Protected Health Information (PHI) and will use it as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed and full payment is received. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney for the purpose of securing payment under this policy of insurance or to any Medical Provider associated with my case to effectively treat me. The authorization is in effect until 90 days from the date the last bill is collected.

I have received a copy of the Notice of Information Practices. _____
Initial

A photocopy of this Assignment shall be considered effective and valid as the original. _____
Initial

_____ _____
Patient Signature Date

_____ _____
Patient Printed Name Staff Witness Signature

_____ _____
Parent or Guardian Signature (if under 18) Date

_____ _____
Parent or Guardian Printed Name Staff Witness Signature

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Health Status Form

Date: | Patient Name:

Present Complaint: | Date of Onset:

How did injury occur? Please check all that apply:

☐ Accident ☐ Fall ☐ Gradually ☐ Work Injury ☐ Lifting ☐ Sport ☐ Surgery ☐ Other _____

Do you have pain? ☐ Yes ☐ No | Rate Pain (0 no Pain – 10 high pain) At Best: _____ At Worst: _____

Have you had physical therapy for this problem before? ☐ Yes ☐ No | If yes, when:

What tests have been done for this condition? (check all that apply)

☐ CT Scan ☐ MRI ☐ X Ray ☐ EMG ☐ Bone Scan ☐ Ultrasound ☐ None ☐ Other _____

Describe your overall general health : ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Past Medical History

If yes, please provide details

High Cholesterol	☐ Yes	☐ No	_____	Stroke	☐ Yes	☐ No	_____
High Blood Pressure	☐ Yes	☐ No	_____	Blood Clots	☐ Yes	☐ No	_____
Heart Problems	☐ Yes	☐ No	_____	Pacemaker	☐ Yes	☐ No	_____
Seizures/Neurological	☐ Yes	☐ No	_____	Cancer/Tumor	☐ Yes	☐ No	_____
Behavioral/Learning	☐ Yes	☐ No	_____	Diabetes	☐ Yes	☐ No	_____
Anxiety/Depression	☐ Yes	☐ No	_____	Hepatitis/HIV	☐ Yes	☐ No	_____
Genetic/Congenital	☐ Yes	☐ No	_____	Asthma/COPD	☐ Yes	☐ No	_____
Are you pregnant?	☐ Yes	☐ No	_____	Do You Smoke?	☐ Yes	☐ No	_____
Bone Joint Problems	☐ Yes	☐ No	_____	If so, how much?			_____

Other (describe): _____

Significant Past Surgeries: _____

Medications/Allergies

List all medications (prescription & OTC medication/vitamins) or attach list, include dosage and method: _____

_____

_____

List all food and medical allergies (include latex & adhesives): _____

_____

_____

Daily Activities

What do your job and/or home duties require? Check all that apply:

☐ Computer Work	☐ Standing	☐ Reaching	☐ Carrying
☐ Kneeling/Squatting	☐ Walking	☐ Climbing	☐ Lifting
☐ Repetitive Movement/Twisting	☐ Writing	☐ Pushing/Pulling	☐ Other _____

_____ _____

Signature of Patient or Legally Authorized Representative | Date

C.H.A.M.P
PHYSICAL THERAPY & PILATES

☐ **Yes, keep me informed about clinic updates including seminars and health education.**

Email address: _____

CANCELLATION AND NO-SHOWS POLICY

Our goal is to provide everyone with quality care at a day and time that is most convenient for them. Should you need to cancel your appointment, we require all patients notify us at least 24 hours in advance. ***If you do not inform us within 24 hours or do not show for your appointment, there will be a $35.00 Cancellation/No-show Fee billed directly to you***. We have an answering machine available after hours and on weekends. Two consecutive no-shows will result in any future appointments being cancelled and further scheduling at the discretion of your therapist.

Signature: _____ Date: _____

EQUIPMENT / NON-PATIENT POLICY

The safety of everyone, both patients and friends/family members who are not current patients, is our primary concern. Children and adults who not receiving physical therapy are not allowed on our equipment. Equipment is for therapeutic purposes and not for unsupervised play. I hold CHAMP Physical Therapy and Pilates harmless of any liability which is caused by not adhering to this policy.

Signature: _____ Date: _____

Please print your name clearly: _____ Today's Date _____

Please answer the following

1. **Have you had any international travel in the last 2 weeks?**

2. **Have you had contact with anyone with confirmed COVID-19 in the last 14 days? (Yes or No)**

3. **Please circle any symptoms you currently have or have had in the last 14 days.**

Fever greater than 100 deg F	Chills
Difficulty breathing	Sore Throat
Cough	Loss of taste smell

If you answered yes to question 2 and/or 3, please call your primary care provider or your State Department of Health for further direction.

Arizona State Dept. of Health: (602) 542-1025
Arizona State Dept. of Health latest info about Arizona's Response or if you have a specific question: 1-844-542-8201

NOTE: The CDC and the Arizona Department of Health Services recommends that you do NOT visit an emergency medical facility unless you are severely ill. Please call ahead and let any emergency medical facility know why you are coming. Meanwhile, do not get close to anyone with a compromised immune system or other underlying condition.

Thank you for your cooperation and willingness to ensure a healthy outcome for all our patients and employees.