16572 W. Greenway Rd.
Surprise, AZ 85388
Office: (623) 584-3400
Office: (623) 584-5434

PATIENTS NAME ______________________________________ DATE OF BIRTH_______________ AGE _____

MAILING ADDRESS ____________________________________ CITY ____________________ ZIP ___________

HOME PHONE (_____) ____________________CELL PHONE (______)____________________ SEX: M ☐ OR F☐

PATIENT SSN________-________-____________DRIVER'S LICENSE # _________________________________

PATIENT EMPLOYER__________________________PATIENT EMAIL ________________________________

OCCUPATION____ WORK PHONE (____) _________________

REFERRING PHYSICIAN____________________________PRIMARY PHYSICIAN________________________

DATE OF INJURY_______________________ DATE OF SURGERY____________________________________

PERSON TO CONTACT IN CASE OF EMERGENCY: ____
(First & Last Name)

___________________________________ ___________________________________
RELATIONSHIP PHONE

IF PATIENT IS A MINOR PLEASE PROVIDE US WITH THE FOLLOWING INFORMATION:

PARENT/GUARDIAN NAME______________________________________ SSN________-_______-__________

PARENT/GUARDIAN EMPLOYER ______________________________ WORK-PHONE(______)_____________

INSURANCE ____
(Please present card at time of service)

___________________________ ___________________________ ___________________________
Policy Holder Name (If not patient) Policy Holder Date of Birth (If not patient) Tricare Sponsor Soc. Sec # (If not patient)

WAS THIS A MOTOR VEHICLE ACCIDENT____________**IF YES PLEASE COMPLETE THE FOLLOWING**

NAME OF VEHICLE INSURANCE_______________________________ PHONE (_____)_____________________

NAME OF PERSON INSURED______________________________ ADJUSTER NAME ______________________

ACCIDENT CLAIM#_____________________________

**** PLEASE CHECK EACH BOX TO CONFIRM THE FOLLOWING:**

- ☐ I HEREBY AUTHORIZE GUIDRY PHYSICAL THERAPY TO PROVIDE TREATMENT AS PRESCRIBED BY MY PHYSICIAN.
- ☐ I HEREBY ASSIGN ALL INSURANCE BENEFITS FOR SERVICES RENDERED TO BE PAID DIRECTLY TO GUIDRY PHYSICAL THERAPY.
- ☐ I UNDERSTAND THAT IF MY INSURANCE CO/THIRD PARTY PAYER DENIES PAYMENT OR MAKES PARTIAL PAYMENT I AM RESPONSIBLE FOR THE BALANCE DUE.
- ☐ I HEREBY AUTHORIZE THE RELEASE OF MEDICAL RECORDS TO GUIDRY PHYSICAL THERAPY AND ANY PERTINENT INFORMATION CONCERNING THE PATIENT FOR THE PROVISION OF CARE AND FOR OBTAINING INSURANCE REIMBURSEMENT.
- ☐ I UNDERSTAND THAT I AM LEGALLY RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED BY GUIDRY PHYSICAL THERAPY. INSURANCE IS BEING BILLE AS A COURTESY. I AM RESPONSIBLE FOR PAYING ANY DEDUCTIBLE OR CO-INSURANCE AMOUNTS.
- ☐ I UNDERSTAND THAT CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE.

SIGNATURE OF PATIENT/PARENT/GUARDIAN________________________________ DATE______________

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NAME:____

DATE OF NEXT MD APPOINTMENT:_________________________

Describe briefly the history of your present ACCIDENT, INJURY, ILLNESS OR CONDITION:
Onset Date: ___________ Description: ____

____

____

Please list any special concerns, questions or expectations: _______________________________

____

Have you fallen in the past year? ________ If so, how many times? _________ If so, did you sustain an injury?____

Have you had **any physical therapy** during the current calendar year? _____ Have you had physical therapy for the same condition for which you are here today? ______ If yes, please indicate where and when:

____

List **ALL** medications you are currently taking: ____

____

____

____

Please list recent diagnostic studies (CAT scan, MRI, X-ray, ETC.) & where taken: ____________________

____

Do you have METAL anywhere in your body (other than teeth), such as pins/plates, pacemaker, stints, etc.? Describe

____

Please list **ALL** surgeries you have had; please give procedures and dates, if possible:_______________

____

____

Have you ever had: (Please mark yes or no)

Condition	Yes	No
High blood pressure	Yes ☐	No ☐
Heart disorders	Yes ☐	No ☐
High Cholesterol	Yes ☐	No ☐
Lung Disorders	Yes ☐	No ☐
Circulation disorders	Yes ☐	No ☐
Dizzy Spells	Yes ☐	No ☐
Seizures	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐
Arthritis/Osteoarthritis	Yes ☐	No ☐
Osteoporosis	Yes ☐	No ☐
Cancer	Yes ☐	No ☐
Pacemaker	Yes ☐	No ☐
Are you pregnant?	Yes ☐	No ☐
Allergies to tapes or lotions?	Yes ☐	No ☐
Tobacco use	Yes ☐	No ☐

SIGNATURE: ____ DATE: _______________

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Dear Patient:

We want to thank you and your referring physician for choosing Guidry Physical Therapy as your outpatient treating facility.

We will bill your insurance company however; insurance coverage varies for physical therapy benefits. It is your responsibility to contact your insurance plan to verify coverage, deductibles and co-pays.

*****All co-pays are due at time of service*****

Missed Appointments:
A specific appointment time will be reserved for you. It is important to the outcome of your treatment that you are consistent with your attendance. If you need to cancel or reschedule an appointment, it is courteous to do so, greater than 24-hours in advance so that time can be offered to other patients. We fully understand that emergencies arise and we will take that into consideration.

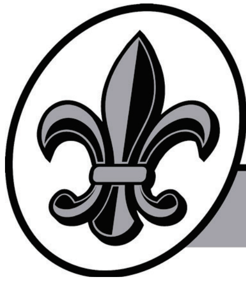
A late cancellation fee of $25 will be charged for the missed session. Please note that it is your responsibility - insurance companies do not reimburse for missed appointments.

In the event that your account has to be sent to collections for nonpayment a 35% collection fee will be charged.

Thank you.

____
Print Name

____ _______________
SIGNATURE DATE



GUIDRY
PHYSICAL THERAPY

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Summary Notice of Privacy Practices

Guidry Physical Therapy is committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THE FOLLOWING CAREFULLY.

"Protected health information" is information about you, including demographic information, present or future physical or mental health or condition and related health care services. We are required by law, in most instances, to have your written consent before we use or disclose to others your medical information for the purpose of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may sometimes use or release your information without your consent or authorization as may be required or permitted by certain laws.

You have the right to the following:

- Look at and make copies of your protected health information
- Ask us to not release parts of your protected health information
- To be told when we release your protected health information
- Ask us to contact you only in certain ways
- Request us to change parts of your protected health information
- File a complaint if you think your rights have been violated

THIS IS ONLY A SUMMARY

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our notice from time to time. You have the right to obtain a copy of our most recent Notice in effect. Please ask the front desk if you wish to receive a full copy of our Notice of Privacy Practices.

If you have any questions, concerns, or complaints about the Notice or your protected health information, please contact Kyle Guidry PT, DPT, ATC at (623)584-3400.

My signature below indicates:

- I have been provided with the Summary Notice of Privacy Practices and I am aware that I may obtain the most recent copy of the Notice of Privacy Practice in its entirety at the front desk or by calling (623) 584-3400
- I authorize Guidry Physical Therapy to use and disclose my health and medical information for the purposes of Treatment, Payment, and Healthcare Operations.

____ ____________

Signature of Patient/Guardian Date