Six Tucson Locations! www.agilitypt.com

1605 E River Road Ste 201
Tucson AZ 85718
Phone (520)884-9819 Fax (520) 867-6681

1777 W St. Mary's Road
Tucson AZ 85745
Phone (520) 884-9819 Fax (520) 884-0175

6206 E. Pima #3
Tucson, AZ 85712
Phone (520) 733-6227 Fax (520) 733-7328

1880 W Orange Grove Road
Tucson AZ 85704
Phone: (520)797-2090 Fax (520)797-3138

8987 E Tanque Verde Rd, #301
Tucson AZ 85749
Phone (520) 884-4292 Fax (520) 203-7419

7355 S. Houghton Rd. #109
Tucson, AZ 85747
Phone (520)664-9100Fax (520)664-1099

Thank you for choosing **Agility Spine and Sports Physical Therapy** for your Physical Therapy Services!

To assist with the registration process of our upcoming appointment, we ask that you complete the enclosed forms and bring them with you to your first appointment. Although you may have registered with us before, completing these forms will ensure that our records are current and accurate. If there are any questions in completing the enclosed forms, please contact our office at 520-884-9819 and we would be more than happy to assist you.

At your first appointment, please bring any written orders, physician prescriptions, and pertinent diagnostic film results or other tests. We need a medication list including all prescriptions medication, over the counter medications, herbal supplements and vitamin/mineral/dietary (nutritional) supplements with the name, dosage, frequency and how it is taken (IE: by mouth). Please wear comfortable, loose fitting clothing, and supportive shoes to every visit. Skirts, dresses, tight jeans, etc. should be avoided if possible.

You will also be required to provide us your insurance cards and a picture identification card for scanning into your chart. Please note, depending on your insurance plan, we may be required to collect your co-payment, coinsurance, deductible or other fees not covered by insurance at the time of your appointment. We do our very best to make you aware of these costs prior to your first visit and prefer to be as transparent as possible regarding your out of pocket costs. We appreciate your cooperation in paying your portion of the bill on the days of your visits. For directions to our offices, please visit our website agilitypt.com.

Again, thank you for choosing Agility Spine and Sports! We look forward to serving your needs.

All services are available without distinction to all program participants regardless of race, color, national origin, handicap, age or sexual orientation

AGILITY Spine & Sports Physical Therapy

Your Name: ____

Referring Physician: _________________________________

Dear Patient: Please provide us with this important health history information. If you don't understand a question, your therapist will assist you. Thank you.

1. For what condition are you seeking treatment here?____

2. Onset date:____

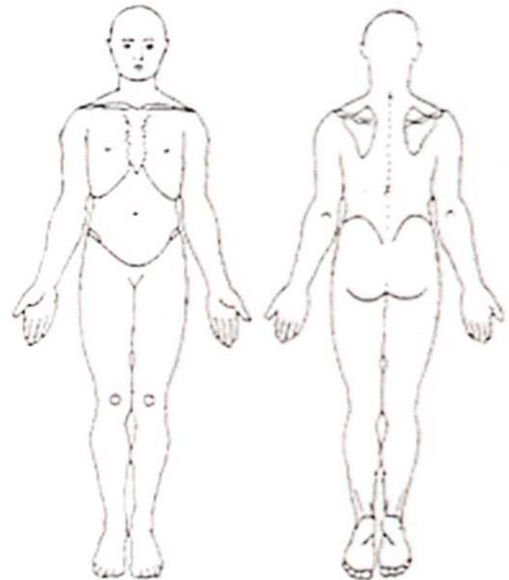
3. Cause of condition? ____

4. Have you been treated for this or a similar condition before? No Yes (Continue with the following)
   Medical Doctor Chiropractor Exercise Medication
   Physical Therapy Massage Acupuncture Other:

5. What are your symptoms? Pain Numbness Weakness Tingling Loss of Motion
   Nausea Dizziness Other: ____

*If you have pain, please complete this section, if not please skip to question 7.

6. A. Rate the average amount of pain you have using a "0" to "10" scale where "0" equals no pain and "10" equals the worst pain imaginable. Mark the line at the point that represents your pain.



B. Please mark areas of pain on the diagram to the right...

C. Is your pain getting: ☐ Better ☐ Worse ☐ Same
   Pain is: ☐ Constant ☐ Intermittent

D. Time of day pain is worse: ☐ Upon Wakening
   ☐ A.M. ☐ Midday ☐ P.M. ☐ Late Night
   ☐ Sleep is disturbed ☐ Varies ☐ Same

E. What makes the pain worse: ☐ Lie ☐ Sit ☐ Sit-Stand
   ☐ Stand ☐ Walk ☐ Bend ☐ Lift ☐ Stairs
   ☐ Reach ☐ Deep Breath ☐ Cough/Sneeze
   ☐ Rotate R L Other:___________________________

F. Pain is better with: ☐ Medication ☐ Heat ☐ Ice ☐ Rest
   ☐ Position/Posture ☐ No Relief ☐ Other: ____

7. nostic tests performed? ☐ None ☐ X-ray ☐ MRI ☐ CT Scan ☐ Arthrogram ☐ Other:___________

8. On the job injury? No Yes - Light Duty? No Yes - Restrictions:

9. Occupation Physical Demand of Job: Lifting Sitting Phone/computer use
   Overhead activity Driving Extended Standing

10. A. Exercise/Activity level prior to onset of condition: Walk Run Bike Swim

Weight Train   Aerobics Class   Sport: ______________ How many times per week? ________

B. Exercise level now: None   Reduced   Same

11. What are your goals for therapy: Restore Function   Return to Work   Learn Self-Help Program
    Reduce Pain   Return to sport   Reduce risk of falls   Other:
12. Current stress level: Mild   Moderate   High
13. Medical History:

A. When was your last medical physical?   Months /   Years

B. Have you been diagnosed or experienced any of the following? Please circle all that apply:

High Blood Pressure   Arthritis   Heart Condition

Depression   Emphysema   Rheumatoid Arthritis   Hepatitis

Cl Tuberculosis   Sleep Disorder   Lung Disorder   Osteoporosis

Fibromyalgia   Kidney Disease   Cancer / Tumor   Other: ______________

Asthma   Ulcers   Bowel/Bladder Problems

Diabetes   Stroke   Deep Vein Thrombosis

Anemia   Thyroid Problems   Epilepsy

Fracture   Weakness Dizziness / Blackouts

Muscle or Joint Problems i.e., Neck, Back, Knee ____

Surgery: ____

Balance Problems

14. Have you fallen in the past year?   Yes   No
15. Circle all the following medications have you taken in the last week:

A. Over the counter: Aspirin   Decongestants   Laxatives   Tylenol

Antihistamines   Advil / Ibuprofen   Vitamins / Mineral   Other:

B. Prescription for: Pain   Heart   Blood Pressure   Muscle Relaxants   Antibiotics   Diabetes   Steroids
   Hormones Stomach/ Anti-Inflammatory

Other:

16. Have you had a recent change in your medication? Yes   No
17. Have you had a recent (within last 2-3 months) change in: Appetite   Weight   Energy   Balance
18. Do you regularly consume: Alcohol   Caffeine   Cigarettes?

I certify that the following information is complete, true and correct. I have been fully informed of and understand the nature and extent of the activity in which I will participate associate with the Physical Therapy and Performance Testing Program and I hereby consent to the same. I am aware of no physical or medical condition that I have that will in any way be adversely affected by or impaired my ability to fully participate in the services associated with this program.

Therapist Signature: ____________________   **Patient signature**: ____________________   **Date**: ____________

Consent for Treatment

I, or my representative, recognizing the need for care, consent to all services ordered or deemed appropriate by my physician or physical therapist. I understand that I will be evaluated by a licensed physical therapist. A physical therapist, physical therapist assistant or physical therapy technician may conduct all treatment. I understand the nature of my condition, that certain risk may be involved, and that there are no guarantees for treatment success. I understand that I can discuss with the treating therapist what the potential risk and benefits of a specific treatment might be. I understand that rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature. I understand that I have the right to decline any portion of my treatment at any time before or during a treatment session. In the event of a change in the medical status, I understand that my treatment may be modified or stopped. I understand that I have the right to choose my physical therapy clinic. I reserve the right to withdraw my consent at any time and will communicate directly with the treating physical therapist.

I consent to treatment at Agility Spine and Sports Physical Therapy & Rehabilitation, LP.

Patient Name: ______________________ **Patient Signature**: ________________________ **Date:** ____________

Treatment of minors: If patient is a minor, Guardian Name: ___________________________

I, as 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. By signing below, I also consent to treatment of the above -named minor at Agility Spine and Sports Physical Therapy & Rehabilitation, LP.

Guardian Signature: ____________________________ **Date:** _________________

Liability: I know and agree that Agility Spine and Sports Physical Therapy & Rehabilitation, LP is not responsible for loss or damage to personal valuables. **Signature:** ________________________

Waiver and Release: I hereby release, discharge and acquit Agility Spine and Sports Physical Therapy & Rehabilitation, LP, 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.

Signature: __________________________________

May we send you emails relating to your care with us? ___ Yes ___ No **Signature:** _________________________

By providing your email address below, you understand that email communications may NOT be secure with the risk of unauthorized access to your information.

Your Email address: ____

May we send you texts relating to your care with us? ____ Yes ____ No **Signature:** ____________________________

By providing your text number and service provider below, you understand that text messages will NOT be secure with the risk of unauthorized access to your information.

Your Text number: ________________________________Service Provider: ________________________

Financial Policy and Notice of Patient Information Practice

I certify that all information on the patient demographics page is correct and that myself or my dependent(s) have health insurance coverage as listed. I assign directly to Agility Spine and Sports Physical Therapy, insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for my co-payments, coinsurances and/or deductibles, which is due at the time of treatment. I authorize the use of my signature on all insurance forms. Agility Spine and Sports Physical Therapy & Rehabilitation, LP, including its employees, may use my treatment care information and may disclose such information to my health insurance company(ies) and their agents for payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

I understand and agree, whether signing as an agent or as a patient and whether insured or a member of a health insurance organization, that in consideration of the services to be rendered, that I hereby individually obligate myself to pay the account of the medical facility in accordance with the regular rates, terms and fees on the unpaid balance set out by the facility. If it is necessary to place the account with a collection agency to collect the balance due, an additional 35% of the principle balance due will be added to cover the collection fees. In addition, should legal action become necessary to collect the balance due, I understand that I will be responsible for reasonable attorney's fees, interest and court costs. I also understand that if my account is placed with an agency for collection or placed with an attorney for legal action that a credit report will be pulled for the sole purpose of collecting the delinquent account.

I have received and fully understand the Agility Spine and Sports Physical Therapy Notice of Privacy Practices and Statement of Patient Rights. I understand that Agility Spine and Sports PT may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that Agility Spine and Sports PT will consider requests for restriction on a case-by-case basis but does not have to agree to requests for restrictions. I hereby consent to the use and disclosure of my personal health information for purposes as noted in the Agility Spine and Sports PT's notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name: _____________________________ **Patient Signature:** ______________________**Date**: _____________

If patient is a minor, Guardian Name: ___________________________**Guardian Signature:** _____________________

Date: __________________

Cancellation Policy

At Agility Spine and Sports Physical Therapy, we take your time and treatment seriously. It is important to the progression of your treatment that you attend your appointments. I understand that multiple cancellations without 24-hour notice or "no-shows" may result in my discharge from care.

Patient Name: _____________________ **Patient (Guardian) Signature:** _______________________ **Date:** ________