ARMADA PHYSICAL THERAPY

First Name: _____ M.I. _____ Last Name: _____

Address: _____ Zip Code_____

Home Phone: _____ Work Phone: _____ Other: _____

Email Address: _____

Date of Injury: _____ Worker's Compensation: YES NO Auto Accident: YES NO

Primary Physician: _____Referring Physician: _____

Attorney: YES NO (If Yes, list name and address of law firm):_____
_____

Primary Insurance: _____ Secondary Insurance: _____
Provide copies of Insurance Card

Emergency Contact:
First Name: _____ M.I, _____ Last Name: _____

Relationship: _____ Home Phone: _____ Work Phone: _____
Other: _____

Guardian Information (if client is 17 years old and younger):

First Name: _____ M.I, _____ Last Name: _____

Home Phone: _____ Work Phone: _____ Other: _____

SSN: _____ Birthday: _____ Relationship: _____

PATIENT CANCELLATION AND NO SHOW AGREEMENT

Your recovery is important to us. Your appointments are essential to the recovery and are based on an individualized prescription by your Physical Therapist. We ask that you notify Armada Physical Therapy 24 hours in advance of any cancellation, so that your therapist may treat another patient during that timeslot. All patients that do not provide 24 hours' notice or are a no show are subject to a $40.00 cancellation/no show fee.

Patient Signature: _____ Date Signed: _____

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Health Information

Medical History

Have you ever been told that you have:

Cancer	Yes/No	Asthma/hay fever	Yes/No
Diabetes	Yes/No	Rheumatic/scarlet fever	Yes/No
Hypertension or high blood pressure	Yes/No	Hepatitis/jaundice	Yes/No
Heart disease/condition	Yes/No	Cirrhosis/liver disease	Yes/No
Angina or chest pain	Yes/No	Neurological disorders	Yes/No
Shortness of breath	Yes/No	Chronic bronchitis	Yes/No
Stroke/TIA	Yes/No	Pneumonia	Yes/No
Kidney stones/diseases	Yes/No	Emphysema/COPD	Yes/No
Urinary tract infection	Yes/No	Migraine headaches	Yes/No
Allergies	Yes/No	Ulcers/stomach problems	Yes/No
Hypoglycemia	Yes/No	Arthritis/gout	Yes/No
Incontinence of bowel or bladder	Yes/No	Thyroid conditions	Yes/No

Other: _____

Medical Testing

1. Please list any medications, vitamins, or supplements that you are currently taking.
   _____
   _____
   _____
2. Have you had any medical imaging done recently such as x-ray, MRI, CT, or ultrasound? Yes/No
3. Have you had any lab work done recently (urinalysis or blood tests)? Yes/No
4. Please list the date and type of any surgeries you have ever had.
   _____
   _____
   _____

General Health

1. Have you had any recent illnesses within the last 3 weeks? Yes/No
2. Do you have any sores that have not healed? Yes/No
3. Have you had any changes in size, shape, or color of a wart or mole? Yes/No
4. Have you had any unexpected weight gain or loss in the past month? Yes/No
5. Do you ever experience dizziness or fainting? Yes/No
6. Have you been experiencing unusual fatigue or weakness in the past 3 weeks? Yes/No
7. Are you currently or could possibly be pregnant? Yes/No

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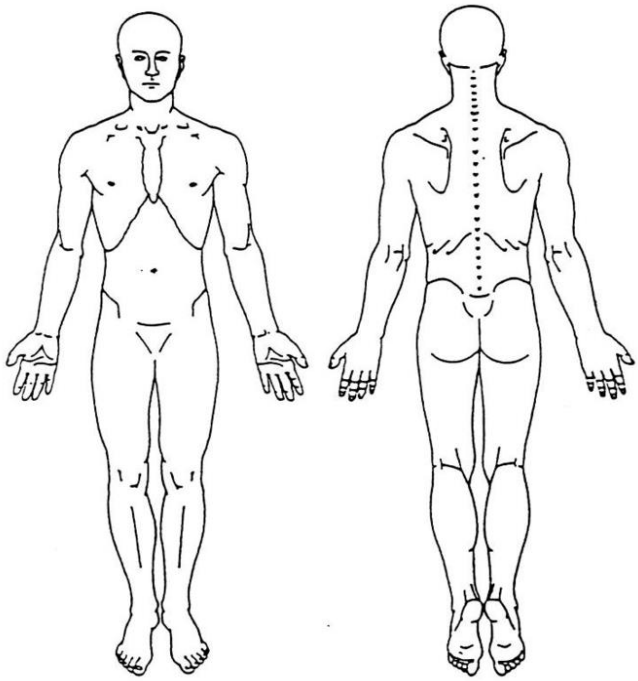
Body Diagram

Instructions:
On the body diagram below, please indicate where your pain is located at the present time. Please do not indicate areas of pain that are not related to your present injury or condition,



Indicate on the line below how you would describe your present pain by placing a mark on the line between the two extremes of experiencing no pain at all and experiencing the worst pain you have ever felt.

No Pain — Worst Pain Possible

How would you describe your pain?

- ☐ Sharp
- ☐ Dull/Aching
- ☐ Burning
- ☐ Tingling/numbness
- ☐ Throbbing
- ☐ Other: _____

2929 Coors Blvd NW Suite 100, Albuquerque, NM 87120 Office: 505-344-2922 Fax: 505-214-5030
6400 Jefferson St NE Suite 102, Albuquerque, NM 87109 Office: 505-836-4899 Fax: 505-214-5030
8616 Menaul Blvd NE Suite A, Albuquerque, NM 87112 Office: 505-292-4784 Fax: 505-214-5030
2401 Cabezon Blvd Suite 102, Rio Rancho, NM 87124 Office: 505-994-2599 Fax: 505-214-5030

ARMADA PHYSICAL THERAPY

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for **Armada Physical Therapy** to furnish medical care and treatment to _____ that is considered necessary and proper in diagnosing or treating his/her physical and mental condition.

Patient/Guardian/Responsible Party Signature: _____ Date: _____

AUTHORIZATION BENEFIT ASSIGNMENT-FINANCIAL RESPONSIBILITY-RELEASE OF INFORMATION

I authorize **Armada Physical Therapy** to release to the insurance carrier any information needed for the payment of any claim. I authorize payment to **Armada Physical Therapy** from my insurance carrier or third party payer.

I agree to pay any applicable co-payment at the time of service and coinsurance and/or deductibles as agreed between **Armada Physical Therapy** and me. I understand and agree that my insurance benefits may cover all charges and that I am responsible for those charges not covered by my health insurance or third payer. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

The above may not apply for those patients that are considered Worker's Compensation. However, be advised that if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for the services rendered to you.

A photocopy of this authorization is to be considered as valid as the original. By my signature, I authorize **Armada Physical Therapy**, to release all information necessary, including medical records, to secure payment.

Patient/Guardian/Responsible Party Signature: _____ Date: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I have had a full opportunity to read the **Armada Physical** Therapy Notice of Privacy Practices. I understand that by signing this consent to **Armada Physical Therapy** to use and disclose my protected health information to carry out treatment, payment activities and health care operations. I understand the terms of this notice may change time, and **Armada Physical Therapy** will always post the current notice at the clinic, on the website, and have copies available for distribution.

Indicated below are individuals whom **Armada Physical Therapy** may speak to regarding my treatment. Please list names.

□ Spouse_____ □ Father_____

□ Mother_____ □ Other_____

Listed below are individuals whom I request restriction regarding my protected health information.

□ Not Applicable □ _____

We may need to contact you. Do we have your permission to leave a confidential message at the phone numbers you provide us?

□ Yes if yes: Home #: _____ Mobile #: _____ Other #: _____

□ No

Patient/Guardian/Responsible Party Signature: _____ Date: _____

SIGNATURE FOR CONSENT

By my signature below, I acknowledge that I have read, understand and agree to the terms and conditions contained in **the Consent for Care and Treatment**, the **Authorization** to release all information necessary to secure payment, and **the Consent for Use** and **Disclosure of Health Information**.

Patient/Guardian/Responsible Party Signature: _____ Date: _____

WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I hereby acknowledge that I have received a copy of The Notice of Privacy Practices.

Relationship to patient (if patient is minor) _____

Patient/Guardian/Responsible Party Signature: _____ Date: _____

CREDIT CARD AUTHORIZATION

I hereby authorize Armada Physical Therapy to charge my credit/debit card for services rendered including any charges incurred related to the cancellation and no show agreement.

Credit Card Type: ____ Visa ____ MasterCard ____ Discover _____AmEx

Credit Card Number: _____-_____-_____-_____

Expiration Date: _____ Card Identification Number: _____ (last 3 digits located on the back of the credit card)

Amount to Charge: $_____ (USD)

Patient Signature: _____ Date Signed: _____

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