CANYON PHYSICAL THERAPY AND AQUATIC REHABILITATION

"Uncompromising Care"

Hello, thank you for choosing **Canyon Physical Therapy & Aquatic Rehabilitation**. We are excited to serve you and look forward to providing you "Uncompromising Care". Please take a moment to review these frequently asked questions.

Q~ What should I bring to my first appointment?

A~ Please **complete** the included packet and bring it in with you on your first visit.
Also please bring with you:

- Your picture ID
- Insurance card(s)
- Therapy prescription from your physician (if we do not already have it)
- FYI: Some insurance plans will only allow treatment as prescribed by your Physician

Please arrive 15 minutes early for the first appointment.

Q~ What should I wear to my first appointment?

A~ Please dress comfortably in loose fitting clothing that will allow access to the area of your body that will be evaluated by the Physical Therapist.
*****If your physician has ordered Aquatic Physical Therapy you may bring your pool gear (i.e. swim clothes and towel, as we do not provide one) however, it may not be needed on the first visit.

Q~ How long will my appointment last?

A~ Your first visit (initial evaluation) will last approximately 1 hour and 30 minutes. Return visits will last 1-2 hours depending on your course of treatment.
*****If you will be receiving Aquatic Physical Therapy your visits will tend to last closer to 2 hours.

Q~ What should I do if I will be unable to make my appointment?

A~ If you are unable to make your scheduled appointment, please call at least 24 hours before to reschedule. This will provide us ample time to schedule another patient. If you no show for your Initial Evaluation, we will not follow up and you will be removed from the schedule. You may not be rescheduled if you no show to the evaluation. If you do not show for your visit or repeatedly cancel within 24 hours you will be removed from the schedule and a compliance record will be sent to your Dr. Please remember for Physical Therapy to be effective you must maintain a consistent schedule as prescribed by your Physical Therapist and Physician.

Q~ Where is Canyon located?

A~ **Canyon Physical Therapy and Aquatic Rehabilitation** is located at 2852 N. Navajo Dr. Ste. A. in Prescott Valley. We are on the **South** side of Hwy 69 next to the drive-thru Wells Fargo Bank and adjacent to the Americas Best Value Inn.

Should you have any further questions please call (928) 772-9797 and someone will be happy to assist you. Again, thank you and we look forward to meeting your Physical Therapy needs.

Canyon Physical Therapy & Aquatic Rehabilitation
2852 N Navajo Dr. Suite A • Prescott Valley, AZ 86314

Patient Name _____ DOB _____ Age _____
Mailing Address _____ Apt. #_____
City_____ State_____ Zip Code_____ Phone _____
SSN_____ Marital Status: S M D W
Employer_____ Occupation _____
Referred By_____ Primary Care Physician_____
e-mail _____
Is this related to an auto or any other accident, example: motor vehicle / slip & fall? YES NO
Do you have an attorney involved? YES NO
Do you have anyone in healthcare coming to your home? YES NO
Are you attending any Therapy (PT, OT, Speech) elsewhere? YES NO
Is this an Industrial (work related) injury? YES NO

IF YOU ANSWER YES TO ANY OF THE ABOVE, PLEASE CONTACT THE FRONT DESK.

Spouse, Parents, or Emergency Contact

Name_____ Relationship _____ Phone _____

_____ _____

Patient/Responsible Party Signature Date

INSURANCE

SOME INSURANCE PLANS WILL ONLY ALLOW TREATMENT AS PRESCRIBED BY YOUR PHYSICIAN*

Primary Insurance_____

Secondary Insurance_____

Please complete appropriate insurance information for Workers' Compensation Case.

Industrial Carrier_____ Contact Person _____
Phone_____Claim #_____ Date of Injury _____
Employer at Time of Injury _____
Address _____City_____State_____ Zip_____
Contact Person _____ Phone _____

Please complete appropriate information for accident, slip & fall or any incident where an attorney is involved.

Auto Insurance Co._____Policy # _____
Address _____City_____ State_____ Zip _____
Contact Person _____ Phone _____
Name of Policy Holder_____Claim # _____
Date of Accident _____ Do you have an attorney _____
Attorney Name _____ Phone_____

Welcome to Canyon Physical Therapy & Aquatic Rehabilitation!

It is our goal to provide "Uncompromising Care" designed to alleviate your pain and maximize your physical abilities. We will teach you ways to manage your current symptoms and care for yourself in order to prevent injuries in the future. Today you will see a licensed Physical Therapist who will evaluate your injury/condition and tailor a treatment program to meet your individual needs. Together we will set short and long terms goals in an effort to facilitate your rapid recovery. During your rehabilitation process, it is extremely important that you keep all of your appointments and follow the instructions given by your therapist. We look forward to working with you and are committed to your well-being.

Canyon Physical Therapy & Aquatic Rehabilitation

FINANCIAL AGREEMENT

I understand and agree that I am solely responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due upon demand. I understand that insurance claim forms will be submitted to my insurance company as a courtesy only, and that I am primarily responsible for all charges regardless of my existing medical coverage. In the event that my insurance company forwards payment directly to me, instead of Canyon Physical Therapy & Aquatic Rehabilitation, I will immediately deliver such payment directly to Canyon Physical Therapy & Aquatic Rehabilitation. I understand and agree that all bills are considered past due after 30 days and payment is required at such time. Past due accounts will be assessed a 1.5% interest charge per month. We accept Visa, MasterCard, Care Credit, cash or check. Please contact our office if payment arrangements need to be discussed as we accept Care Credit which offers special financing options. Should it become necessary to start collection proceedings for any unpaid account balance, you will be responsible for these collection charges and they will be added to your account. It is agreed that if payment is delayed because Canyon Physical Therapy & Aquatic Rehabilitation has agreed to accept a lien; a recovery charge will be assigned.

CO-PAYMENT, CO-INSURANCE & DEDUCTIBLES

Patients that carry health care insurance should remember that some policies require a co-payment, co-insurance or deductible for each visit. Consequently, it is your responsibility as defined by your policy to make these payments. Also important is that you are responsible for any and all supplies, such as waterproof bandages, braces and exercise equipment, which are provided to you and are not covered by your particular plan.

I understand that a $35 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds (cashier's check, money order or cash).

I understand and agree that I am solely responsible for all deductible amounts, co-payments, and charges incurred which are not covered under my health care plan at the time services are rendered.

I herby give authorization for payment of insurance benefits to be made directly to Canyon Physical Therapy & Aquatic Rehabilitation for services rendered. I understand that I am financially responsible for all charges not paid by my insurance company. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I herby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of the agreement is as valid as the original.

APPOINTMENT OF REPRESENTATIVE

By signing on the lines below you are indicating your consent of treatment and appointment of Canyon Physical Therapy & Aquatic Rehabilitation to act as your representative in the event that reconsideration for the services rendered may need to be requested from the health plan. You understand that Canyon Physical Therapy & Aquatic Rehabilitation may file an appeal or request a State Fair Hearing on your behalf. Copies of all correspondence will be forwarded to you upon request in writing.

ACKNOWLEDGEMENT OF RECIEPT OF FINANCIAL AGREEMENT, AND APPOINTMENT OF RESPRESENTATIVE.

I have received, read and fully understand the above mentioned agreement and agree to the participation of these documents.

_____ _____

PATIENT SIGNATURE (OR LEGAL GUARDIAN SIGNATURE) DATE

Canyon Physical Therapy & Aquatic Rehabilitation
Notice of Patient Privacy & Information Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

Canyon Physical Therapy & Aquatic Rehabilitation's LEGAL DUTY

Canyon Physical Therapy & Aquatic Rehabilitation is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Canyon Physical Therapy & Aquatic Rehabilitation uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide. For example, Canyon Physical Therapy & Aquatic Rehabilitation may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Canyon Physical Therapy & Aquatic Rehabilitation may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Canyon Physical Therapy & Aquatic Rehabilitation's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Canyon Physical Therapy & Aquatic Rehabilitation may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notices of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Canyon Physical Therapy & Aquatic Rehabilitation will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Canyon Physical Therapy & Aquatic Rehabilitation may have violated your privacy right or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Canyon Physical Therapy & Aquatic Rehabilitation's health information practices or if you have a complaint, please contact:

Canyon Physical Therapy & Aquatic Rehabilitation
Kelly Vredeveld, PT, DPT, CSCS
2852 N Navajo Dr. Suite A, Prescott Valley, AZ 86314
Phone 928-772-9797 Fax 928-772-9340

Canyon Physical Therapy & Aquatic Rehabilitation
Cancellation / No Show Policy

The therapists and staff of Canyon Physical Therapy & Aquatic Rehabilitation are glad you are here. *You* are the reason this Physical Therapy practice exists, and we promise to never forget that! Your successful rehabilitation is our top priority. To achieve the best possible outcome we and/or your doctor have recommended a particular treatment schedule. To attain these results, it is very important that you attend your therapy sessions as scheduled.

We promise that 100% of our effort will go into your rehabilitation, but we need 100% from you as well. We reserve time in our schedule specifically for you. With this in mind, we ask your cooperation by making every effort to keep scheduled appointments.

Please take a moment to review the guidelines we have put in place to ensure that you get the most out of your experience at Canyon Physical Therapy & Aquatic Rehabilitation.

- **Please give at least 24 hour notice in the event of a cancellation. If you are unable to give 24 hour notice, please contact us as soon as possible.**

- **If you are more than 15 minutes late, your appointment will more than likely need to be rescheduled due to conflicting appointments and a no show will be recorded for that day. If you are aware that you are going to be late, please call the office and let us know.**

- **If you do not call, you are considered a NO SHOW. If you no show for your Initial Evaluation, we will not follow up and you will be removed from the schedule. You may not be rescheduled if you no show to the evaluation. You will receive one courtesy call after your first No Show of a follow up visit, any additional No Shows will result in removal from any future scheduled appointments. You will need to call to resume and reschedule your appointments for physical therapy. The accumulation of 3 No Show appointments will result in discharge from the therapy program. You will be required to obtain a new order from the referring physician before any further appointments can be scheduled.**

- **Three (3) late cancellations (within less than 24 hours of your scheduled time) within a 30 day period will also result in discharge from the therapy program.**

- **You may be subject to a $25.00 charge for a cancellation without proper notice (notice given within less than 24 hours of your scheduled time). This charge will not be covered by insurance, but will have to be paid out of pocket.**

Worker's Compensation and Personal Injury patient's documents of **any** missed or cancelled appointments are forwarded to your case manager and primary care doctor. This could jeopardize your claim and prolong or stop any benefits you may be entitled to.

Please DO NOT CANCEL if you are feeling worse and believe the treatment is not working. Keep your appointment and discuss any changes with your therapist. Please understand that your pain will probably fluctuate as your course of treatment progresses.

Please DO NOT CANCEL if you are feeling better. Keep your appointment in order to progress your plan and prepare for discharge.

When you don't show as scheduled, three people are hurt. You, because you don't get the treatment you need; the therapist, who now has a space in his/her schedule since the time was reserved for you personally; and another patient who could have been scheduled for treatment if you had given proper notice.

We appreciate the opportunity to provide you "Uncompromising Care". Thank you for your consideration of our staff and other patients.

Canyon Physical Therapy & Aquatic Rehabilitation
Consent of Treatment

I do hereby consent to such treatment by the authorized personnel of Canyon Physical Therapy & Aquatic Rehabilitation as may be dictated by prudent medical practice for my illness, injury or condition. This consent is intended as a waiver of liability for such treatment except acts of negligence.

AGREEMENT TO USE EXERCISE ROOM

As part of your Physical Therapy treatment, we anticipate having you use our exercise equipment area. This area consists of exercise equipment and tables where you may receive treatment. Because of the nature of this arrangement, other patients may see parts of your treatments. We are committed to protecting your privacy and will keep your health information confidential. If at any time during your treatment you ever feel uncomfortable, please request to be moved into a private treatment room.

AQUATIC PHYSICAL THERAPY PROGRAM AGREEMENT TO PARTICIPATE

Aquatic physical therapy can have benefits for a wide variety of patients and diagnoses. This type of rehabilitation can help an individual regain function after an injury. At the same time it helps maintain or improve your current level of fitness while the body heals. It is a safe and progressive type of rehabilitation because it takes place in a gravity eliminated/reduced environment and diminishes impact from weight-bearing joints.

You do not need to know how to swim to participate and your treatment will be directed by a licensed physical therapist. Activities may include water walking, running, stabilization, flotation and using various buoyancy or resistance producing equipment. General strengthening exercise using the water as resistance or assistance, depending upon the goal of treatment, will also be incorporated into your program.

Your program will be designed based upon your specific needs as identified by your physical therapist and approved by your physician. The session will be approximately 30-60 minutes in duration and when the treatment concludes you must exit the pool and supervisional responsibility by the physical therapist is no longer in effect. The pool deck and adjoining areas may be wet and caution must be taken by the patient when ambulating in these areas. You should also leave your self adequate time prior to and after using the pool to change clothing and other personal care needs.

Risks may include, but are not limited to, allergic skin reactions, changes in blood pressure, lightheadedness, eye irritation, swimmer's ear, dehydration and hyperthermia.

It is assumed that the participant will disclose any conditions that may prevent or be relevant to safe participation in the aquatic exercise program. I understand that my participation is voluntary and I can cease participation at any time. This is part of the physical therapy program based upon the physical therapist's evaluation and will conclude once the goals are met or progress plateaus.

ACKNOWLEDGEMENT OF RECEIPT OF CONSENT OF TREATMENT, AGREEMENT TO USE EXERCISE ROOM, AGREEMENT TO USE POOL, CANCELLATION / NO SHOW POLICY, AND THE NOTICE OF PATIENT PRIVACY & INFORMATION PRACTICES.

I have received, read and fully understand the above mentioned documents and agree to the participation of these documents.

_____ _____

PATIENT SIGNATURE (OR LEGAL GUARDIAN SIGNATURE) DATE

Canyon Physical Therapy & Aquatic Rehabilitation
INITIAL PATIENT QUESTIONNAIRE

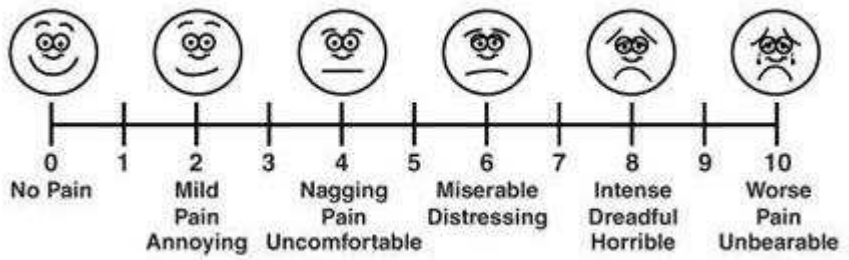
Name_____ Date_____ D.O.B._____
Height_____ Weight_____ Sex: ☐Male ☐Female ☐Right Handed ☐Left Handed

Chief Complaint (Injury/Condition/Surgery/Symptoms):_____
Type of Complaint: ☐Work Comp ☐Auto ☐Surgery ☐Gradual Onset ☐Sports ☐Other_____
Is your Complaint related to an accident? ☐YES ☐NO Type & Date of accident? _____
Description of Complaint:_____
_____
Date of Onset:_____ X-Ray Results:_____ MRI Results: _____
Surgery Date: _____ Type: _____
Have you had Physical Therapy for this or other conditions this year? ☐Yes ☐No Number of visits: _____

Treatments related to this injury (ie. Physical Therapy, Chiropractic, injections….)

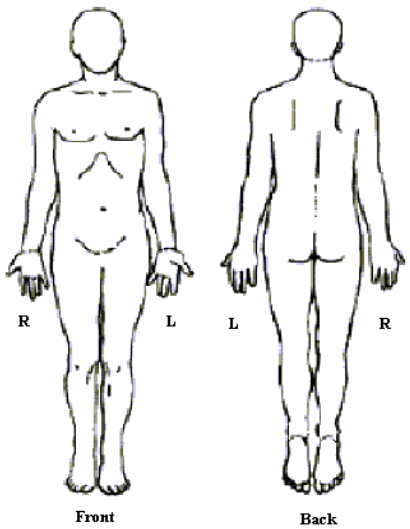
Treatment	Start Date	End Date	Outcome

Please rate your pain/symptoms on the line indicating your current (C), worst (W) and best (B) levels.



Easing Factors:_____
Aggravating Factors: _____
Is your condition getting….. ☐better ☐worse ☐about the same
Have you experienced similar problems in the past? ☐Yes ☐No
Functional Limitations (What are you unable to do, because of your current condition?): _____
_____
Goal(s) of Treament: _____
_____
Occupation (Describe duties/activities):_____
Sports, Hobbies, Recreational Activities: _____

Symptom Area & Description:



Please place symbols of your symptoms on the diagram to the left. Create your own symbols if necessary to describe your symptoms.

X = Sharp
S = Stiff
N = Numbness
A = Achy
D = Dull

Office Use
PT Initials:____

Canyon Physical Therapy & Aquatic Rehabilitation
PATIENT MEDICAL HISTORY

Patient Name_____ Date_____
A complete medical history is necessary for a thorough evaluation. Please answer the following questions.

Have you ever been diagnosed with any of the following:

Condition	Yes	No	Current Status
Arthritis	_____	_____	_____
Asthma/Breathing Disorder	_____	_____	_____
Allergies	_____	_____	_____
Back Pain/Injury	_____	_____	_____
Bleeding Disorder/Blood Clots	_____	_____	_____
Cancer	_____	_____	_____
Circulation Problems	_____	_____	_____
Diabetes	_____	_____	_____
Dizzy Spells	_____	_____	_____
Fractures	_____	_____	_____
Heart Attack/Cardiac Conditions	_____	_____	_____
Head Injury	_____	_____	_____
Hearing/Vision Problems	_____	_____	_____
High Blood Pressure	_____	_____	_____
Kidney/Bladder Trouble	_____	_____	_____
Liver Problems	_____	_____	_____
Depression/Bipolar Disorder	_____	_____	_____
Osteoporosis	_____	_____	_____
Pacemaker	_____	_____	_____
Seizures	_____	_____	_____
Sensitivity to Heat/Cold	_____	_____	_____
Speech Problems	_____	_____	_____
Stroke	_____	_____	_____
Ulcer/Stomach/Bowel Problems	_____	_____	_____
Currently Pregnant	_____	_____	_____
Implants (location: _____)	_____	_____	_____
Total joint replacements	_____	_____	_____
Any recent/unexplained weight loss	_____	_____	_____

Any other illnesses? Please explain:_____

_____

Generally my health is: EXCELLENT GOOD FAIR POOR

Have you recently been ill? (last 6 months) _____

Please indicate illness: _____

Have you been hospitalized? (last 12 months) _____

Please indicate reason _____

Have you had any surgery recently? (last 12 months)_____

Please indicate type of surgery_____

Have you had a fall in the last 12 months? _____ If Yes, how many times? _____ Describe each fall and any related injuries:_____

_____

I verify that the above information is correct and will be used only by the P.T. to ensure my health and safety. I also agree to inform the P.T. should any changes occur as far as my medical history.

Patient Signature_____ Date_____ Office Use: PT Initials ☐

MEDICATION LIST

Per your insurance, please complete all required information on this form.

PLEASE LIST ALL PRESCRIPTIONS, OVER-THE-COUNTER, HERBALS, VITAMIN/MINERALS, DIETARY/NUTRITIONAL SUPPLEMENTS.

MEDICATION NAME	DOSE (ie; MG)	FREQUENCY (ie; times per day)	ROUTE (ie; oral, injection)	FOR TREATMENT OF:	ORDERING DOCTOR

This medication list is current and complete to the best of my knowledge.

Patient Signature:_____ Date: _____

Office Use: PT Initials _____

Patient Health Questionnaire (PHQ-9)

Patient Name: _____ **Date:** _____

	Not at all	Several days	More than half the days	Nearly every day
1. Over the *last 2 weeks,* how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
	☐	☐	☐	☐

Name: _____

EASI Questions

Questions 1-5 to be completed by patient.
Question 6 to be completed by Physical Therapist.

1) Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?	YES	NO	Did not answer
2) Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides or medical care, or from being with people you wanted to be with?	YES	NO	Did not answer
3) Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	YES	NO	Did not answer
4) Has anyone tried to force you to sign papers or to use your money against your will?	YES	NO	Did not answer
5) Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	YES	NO	Did not answer

To be completed by Physical Therapist:

6) Physical Therapist: Elder abuse may be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months?	YES	NO	Not sure

Contact information for assistance related to elder abuse and/or neglect:

In an emergency: 9-1-1 or the police
For non-emergency: (877) SOS-ADULT or (877) 767-2385 – Adult Protective Services (APS)
(602) 264-HELP or (602) 264-4357 – Area Agency on Aging 24hr Helpline