Patient Name____ Date: ______________
Last First

Social Security #________-________-________ Date of Birth_____/_____/__________

Address: ____

______________________ ______________ ______________
City State Zip

Primary Phone # (_____)_________________ Secondary Phone (_____)______________

Sex: F M Marital Status: Married Single Email ____________________________

Employer: ____
Name/Address

Emergency Contact: ____________________Relationship__________Phone______________

Referring Care Physician:______________________________Phone:__________________

Person Responsible for Payment:____
Name Relationship to Patient

Address: ____Phone_______________
Street City State/Zip

INSURANCE INFORMATION:

Primary Insurance : ____
Policy Holder: ______________________________________ Date of Birth_____/_____/________

Relationship to Patient: Self Spouse Parent Guardian Other:____________________

Policy/ID Number:___________________________________ Group Number______________

Employer (Workers Comp claims only):____

Secondary Ins: ____
Policy Holder:__________________________Policy Holder Date of Birth_______________

Relationship to Patient: Self Spouse Parent Guardian Other: ___________________

Policy/ID Number: _____________________________________ Group Number__________

Signature:_____________________________ Date:____________________

INITIAL PATIENT QUESTIONNAIRE

This questionnaire is designed to help us obtain necessary information about your health problems and activity level. Completing the form as completely as possible will help us to develop the most effective treatment program to meet your needs. If you have difficulties answering or understanding these questions, please ask for assistance.

Name: ______________________________ **Date:** ______________________

Age: _______ **Sex:** M F **Height:** ________ **Weight:** _________ **Right handed** _____ **Left Handed** _______

How did you hear about us? (circle one) Doctor Friend Phone book Athletic trainer/coach Other_______________

Is your problem due to any of the following?

_____ Surgery
_____ Auto Accident
_____ Slip/Fall
_____ Lifting/Pulling
_____ Gradual onset of symptoms
_____ Sports Injury
_____ Other Cause: ______________________________

Date of Injury/Onset of symptoms: ______________________________

How long have you experienced this present problem? (week(s)/month(s)/year(s))__________________

Please indicate ALL symptoms:

___ Ache/Dull pain
___ Burning
___ Numbness
___ Spasm/cramp
___ Pins & Needles
___ Stabbing/sharp pain
___ Stiffness
___ Shooting pain
___ Other: please explain: ______________________
___ No pain, unable to perform certain activities

Please circle the numbers that indicate your pain level in the last 3 (three) days. Please indicate the best that your pain level has been and the worst that it had been. Zero indicates no pain and ten indicates the worst your symptoms have been.

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain)

What activities are you unable to perform or are having increased difficulty with as a result of your condition?

a) ______________________________
b) ______________________________
c) ______________________________
d) ______________________________
e) ______________________________
f) ______________________________

Are there specific activities, movements or treatments that relieve your symptoms? Y N
If yes, please explain: ______________________________

____

Is your condition currently getting Better ____ Worse _____ About The Same _____?

Have you experienced similar problems in the past? Y N if yes, when: ______________________

How frequently do you experience flare-ups? ______________________________

Have you had previous treatment for this condition? Y N for similar condition? Y N for different condition? Y N
If you answered yes to any of the above, please indicate the type of treatment and dates: ______________________

____

Please complete the health history on the reverse side of this form also. Thank You.

PAST MEDICAL HISTORY

Condition			Medication/Name
____ Asthma	Y	N	____
____ Allergies	Y	N	____
____ Alcoholism	Y	N	____
____ Diabetes	Y	N	____
____ Heart Disease	Y	N	____
____ High Blood Pressure	Y	N	____
____ Thrombophlebitis	Y	N	____
____ Lung Disease	Y	N	____
____ Rheumatoid Arthritis/ Other Rheumatic Disease	Y	N	____
____ Osteoarthritis/ other Degenerative joint disease	Y	N	____
____ Lupus Erythematosis	Y	N	____
____ Psoriasis	Y	N	____
____ Gout	Y	N	____
____ Cancer	Y	N	____
____ Difficulty controlling bowel and/or bladder functions	Y	N	____
____ Seizure Disorder	Y	N	____
____ Faintness	Y	N	____
____ Muscle weakness where? ____	Y	N	
____ Numbness where? ____	Y	N	
____ Joint Pain where? ____	Y	N	
____ Swelling where? ____	Y	N	

Have you experienced any unusual weight loss? Y N

Have you been admitted to the hospital or undergone any surgical procedures during the past 5 (five) years? Y N
Please list admit diagnosis and dates: ____

Have you received any injections in the joints or muscles? Y N
If yes, please indicate where and date: ____

Please list any special braces, orthotics, walking aids (ie: canes, wheelchairs, etc.) that you currently use:
____

Have you undergone any special testing recently? Y N
XRAY MRI CAT SCAN BONE SCAN
EMG EKG STRESS TEST
Dates: ____

WORK HISTORY

What is your vocation/profession? ____

Briefly describe the type of work that you do: ____

What are your limitations at work? ____

EXERCISE HISTORY

How much exercise do you get? ___ None ___ Walk (____ miles/week) ___ Jog (____ miles/week)

Please list the sport/recreational activities that you are involved in: ____

How long have you been doing the activities listed above? ___ 3 to 6 months ___ 6 months to 1 year ___ Years (how many?)

Do you use nutritional supplements? YES NO Are you interested in learning more about nutritional supplements? YES NO

Continuum Wellness
Physical Therapy & Sports Rehab

Continuum Wellness Physical Therapy

PATIENT NAME:________________________________ DATE:________________

Location Treated:

___ Continuum 3941 E. Baseline Rd. Gilbert AZ 85234

___ Continuum 1075 S. Idaho Rd. # 210, Apache Junction AZ 85119

___ Continuum Wellness 3230 S. Gilbert Rd., # 1, Chandler AZ 85286

FINANCIAL RECORDS CONSENT AND INSURANCE ASSIGNMENT OF BENEFITS:
I certify the information given to me in applying for payment under Title XVIII of the Social Security Act or other financial carriers is correct. I assign payment directly to Continuum Wellness for unpaid charges. I agree to pay CWC for these services and supplies according to its regular rates and charges at the time these services and supplies are rendered. I understand that I am responsible for any health insurance deductibles, co-insurance and any amounts not paid by my insurance carrier. If this account is delinquent, I agree to pay all expenses including but not limited to court costs and actual attorney fees incurred by CWC in collecting this account.

Initials _____

CONSENT FOR TREATMENT:
Knowing that I have a condition requiring treatment at CWC, I do hereby voluntarily consent to such treatment as deemed necessary in the judgment of the physician and therapist.

Initials _____

CONSENT FOR DISCLOSURE FOR DURABLE MEDICAL EQUIPMENT:
I consent for CWC to release my outpatient treatment records to durable medical equipment suppliers to simplify ordering my durable medical equipment. Specific information disclosed will be a patient information face sheet, physician orders and selected information to process my durable medical equipment order.

Initials _____

MEDICAL RECORDS CONSENT:
I consent for CWC to release any information contained in my medical record (including photographs, slides, videotapes, audio recordings or other digital images) to schools, other educational programs and other health care providers for continuing care needs or to my insurance company or employer for payment on my account. I understand that this information may include records regarding mental health treatment, social services counseling, alcohol and drug abuse treatment, psychological or psychiatric treatment, human immunodeficiency virus, (HIV), acquired immunodeficiency syndrome (AIDS-related complex (ARC) or venereal diseases.

Initials _____

CANCELLATION AND NO SHOW POLICY:
Patients are encouraged to keep all scheduled appointments to maximize the benefits of their treatment plan. If a patient is unable to make a scheduled appointment, the patient is expected to give 24 hours advance notice. Two(2) consecutive appointment no-shows may result in discontinuation of the current appointment schedule for the therapy involved. A pattern of frequent absences (cancellation and\or no-shows) will be considered problematic and result in discontinuation of services.

Planned absences from scheduled therapy will not be considered cancellations or no-shows. If a patient provides notice of a planned absence, their on-going schedule may be placed on "hold" for up to two (2) weeks. A renewed prescription and appointment schedule may need to be arranged depending on the length of time which has passed.

I understand the conditions of services at Continuum Wellness Initials _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:
By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices.

________________________________ ____________
Patient/Guardian/Personal Representative Signature *Date*

OFFICE USE ONLY:

Our practice will make a good faith effort to obtain a written acknowledgement of receipt of Notice provided to the patient. If written acknowledgement is not obtained, our practice must document its good faith efforts to obtain such acknowledgement and record the reason why the acknowledgement was not obtained.

_____Refused to sign _____Physically unable to sign _____Other

Employee signature: ______________________ Date: ________________

INSURANCE VERIFICATION ACKNOWLEDGEMENT

Date:_______________

I______________________ understand that Continuum Wellness has
Patient/Guardian

contacted my insurance company, __________________________, in
Insurance Company

A good faith effort to obtain my benefit information including co pay, co-insurance and deductible portions that may be my obligation should insurance deem me responsible. However, Continuum has explained to Me and I am fully aware that this information obtained from the insurance company is by no means a guarantee of payment by my insurance and therefore agree to pay any unpaid portion that my insurance deems my responsibility.

____________________________ ____________________________
CONTINUUM WELLNESS REPRESENATIVE PATIENT/GUARDIAN

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

INTRODUCTION

Continuum Wellness understands that your medical information is private and confidential. Further, we are required by law to maintain the privacy of "protected health information." "Protected health information" includes any individually identifiable information that we obtain from you or others that relates to your past, present or future physical or mental health, the health care you have received, or payment for your health care.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures we will make of your protected health information. We must comply with the provisions of this notice as currently in effect, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a written copy of our most current privacy notice from the Practice's Privacy Officer at 480-503-2010.

PERMITTED USES AND DISCLOSURES

We can use or disclose your protected health information for purposes of treatment, payment and health care operations. For each of these categories of uses and disclosures, we have provided a description and an example below. However, not every particular use or disclosure in every category will be listed.

Treatment means the provision, coordination or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to contact a physical therapist to create the exercise regimen appropriate to your care.

Payment means the activities we undertake to obtain reimbursement for the health care provided to you, including billing, collections, claims management, determinations of eligibility and coverage and utilization review activities. For example, prior to providing health care services, we may need to provide information to your Third Party Payor about your medical condition to determine whether the proposed course of treatment will be covered. When we subsequently bill the Third Party Payor for the services rendered to you, we can provide the Third Party Payor with information regarding your care if necessary to obtain payment. Federal or State law may require us to obtain a written release from you prior to disclosing certain specially protected health information for payment purposes, and we will ask you to sign a release when necessary under applicable law.

Health care operations means the support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient comments and complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your protected health information to evaluate the performance of our staff when caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. In addition, we may remove information that identifies you from your patient information so that others can use the de-identified information to study health care and health care delivery without learning who you are.

OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

In addition to using and disclosing your information for treatment, payment and health care operations, we may use your protected health information in the following ways:

- We may contact you to provide appointment reminders for treatment or medical care.
- We may contact you to tell you about or recommend possible treatment alternatives or other health-related benefits and services that may be of interest to you.
- We may disclose to your family or friends or any other individual identified by you protected health information directly relevant to such person's involvement with your care or payment for your care. We may use or disclose your protected health information to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care of your location, general condition or death. If you are present or otherwise available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not present or otherwise available, we will determine whether a disclosure to your family or friends is in your best interest, taking into account the circumstances and based upon our professional judgment.

- When permitted by law, we may coordinate our uses and disclosures of protected health information with public or private entities authorized by law or by charter to assist in disaster relief efforts.
- We will allow your family and friends to act on your behalf to pick-up filled prescriptions, medical supplies, X-rays, and similar forms of protected health information, when we determine, in our professional judgment, that it is in your best interest to make such disclosures.
- We may contact you as part of our efforts to market our practice's services as permitted by applicable law.
- Subject to applicable law, we may make incidental uses and disclosures of protected health information. Incidental uses and disclosures are by-products of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented.
- We will use or disclose protected health information about you when required to do so by applicable law.

Note: In accordance with applicable law, we may disclose your protected health information to your employer if we are retained to conduct an evaluation relating to medical surveillance of your workplace or to evaluate whether you have a work-related illness or injury. You will be notified of these disclosures by your employer or the Practice as required by applicable law.

SPECIAL SITUATIONS

Subject to the requirements of applicable law, we will make the following uses and disclosures of your protected health information:

Organ and Tissue Donation. If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the Armed Forces, we may release health information about you as required by military command authorities. We may also release health information about foreign military personnel to the appropriate foreign military authority.

Worker's Compensation. We may release health information about you for programs that provide benefits for work-related injuries or illnesses.

Public Health Activities. We may disclose health information about you for public health activities, including disclosures:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to persons subject to the jurisdiction of the Food and Drug Administration (FDA) for activities related to the quality, safety, or effectiveness of FDA-regulated products or services and to report reactions to medications or problems with products;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that an adult patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if the patient agrees or when required or authorized by law.

Health Oversight Activities. We may disclose health information to Federal or State agencies that oversee our activities. These activities are necessary for the government to monitor the health care system, government benefit programs, and compliance with civil rights laws or regulatory program standards.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if the Practice is given assurances that efforts have been made by the person making the request to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release health information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime under certain limited circumstances;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct on our premises; and

- In emergency circumstances, to report a crime, the location of the crime or the victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release health information to a coroner or medical examiner. Such disclosures may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release health information about you to authorized Federal officials for intelligence, counterintelligence, or other national security activities authorized by law.

Protective Services for the President and Others. We may disclose health information about you to authorized Federal officials so they may provide protection to the President or other authorized persons or foreign heads of state or may conduct special investigations.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Serious Threats. As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public or is necessary for law enforcement authorities to identify or apprehend an individual.

Note: HIV-related information, genetic information, alcohol and/or substance abuse records, mental health records and other specially protected health information may enjoy certain special confidentiality protections under applicable State and Federal law. Any disclosures of these types of records will be subject to these special protections.

OTHER USES OF YOUR HEALTH INFORMATION

Other uses and disclosures of protected health information not covered by this notice or the laws that apply to us will be made only with your permission in a written authorization. You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that we already have taken action in reliance on your authorization.

YOUR RIGHTS

1. You have the right to request restrictions on our uses and disclosures of protected health information for treatment, payment and health care operations. However, we are not required to agree to your request. To request a restriction, you must make your request in writing to the Practice's Privacy Officer.

2. You have the right to reasonably request to receive confidential communications of protected health information by alternative means or at alternative locations. To make such a request, you must submit your request in writing to the Practice's Privacy Officer.

3. You have the right to inspect and copy the protected health information contained in your medical and billing records and in any other Practice records used by us to make decisions about you, except:

(i) for psychotherapy notes, which are notes that have been recorded by a mental health professional documenting or analyzing the contents of conversations during a private counseling session or a group, joint or family counseling session and that have been separated from the rest of your medical record;

(ii) for information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding;

(iii) for protected health information involving laboratory tests when your access is restricted by law;

(iv) if you are a prison inmate, obtaining a copy of your information may be restricted if it would jeopardize your health, safety, security, custody, or rehabilitation or that of other inmates, or the safety of any officer, employee, or other person at the correctional institution or person responsible for transporting you;

(v) if we obtained or created protected health information as part of a research study, your access to the health information may be restricted for as long as the research is in progress, provided that you agreed to the temporary denial of access when consenting to participate in the research;

(vi) for protected health information contained in records kept by a Federal agency or contractor when your access is restricted by law; and

(vii) for protected health information obtained from someone other than us under a promise of confidentiality when the access requested would be reasonably likely to reveal the source of the information.

In order to inspect and copy your health information, you must submit your request in writing to the Practice's Privacy Officer. If you request a copy of your health information, we may charge you a fee for the costs of copying and mailing your records, as well as other costs associated with your request.

We may also deny a request for access to protected health information if:

- a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger your life or physical safety or that of another person;
- the protected health information makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or
- the request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to you or another person.
- If we deny a request for access for any of the three reasons described above, then you have the right to have our denial reviewed in accordance with the requirements of applicable law.
-

4. You have the right to request an amendment to your protected health information, but we may deny your request for amendment, if we determine that the protected health information or record that is the subject of the request:

- was not created by us, unless you provide a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment;
- is not part of your medical or billing records or other records used to make decisions about you;
- is not available for inspection as set forth above; or
- is accurate and complete.

In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records. In order to request an amendment to your health information, you must submit your request in writing to the Practice's Privacy Officer, along with a description of the reason for your request.

5. You have the right to receive an accounting of disclosures of protected health information made by us to individuals or entities other than to you for the six years prior to your request, except for disclosures:

(i) to carry out treatment, payment and health care operations as provided above;
(ii) incident to a use or disclosure otherwise permitted or required by applicable law;
(iii) pursuant to a written authorization obtained from you;
(iv) to persons involved in your care or for other notification purposes as provided by law;
(v) for national security or intelligence purposes as provided by law;
(vi) to correctional institutions or law enforcement officials as provided by law;
(vii) as part of a limited data set as provided by law; or
(viii) that occurred prior to April 14, 2003.

To request an accounting of disclosures of your health information, you must submit your request in writing to the Practice's Privacy Officer. Your request must state a specific time period for the accounting (e.g., the past three months). The first accounting you request within a twelve (12) month period will be free. For additional accountings, we may charge you for the costs of providing the list. We will notify you of the costs involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

COMPLAINTS.

If you believe that your privacy rights have been violated, you should immediately contact the Practice's Privacy Officer. We will not take action against you for filing a complaint. You also may file a complaint with the Secretary of Health and Human Services.

CONTACT PERSON

If you have any questions or would like further information about this notice, please contact the Practice's Privacy Officer at 480-503-2010.

This notice is effective as of August 14, 2010.