ENDURANCE REHABILITATION

Patient History

Name: _____ Preferred Name:_____

Date: _____Age: _____ Height: _____ Weight: _____

E-Mail Address: _____

How would you prefer your therapist to contact you? EMAIL PHONE

**All home exercise programs will be emailed*

How did you hear about Endurance Rehab?

- ☐ Internet
- ☐ Friend: _____
- ☐ Sport Club: _____
- ☐ Other: _____
- ☐ Insurance
- ☐ Physician: _____
- ☐ Store: _____

Did a physician refer you for this injury? YES NO If yes, who? : _____

If yes, when is your next follow-up appointment? _____

Have you had physical therapy before? YES NO

Main complaints/symptoms: _____

_____

Pain Level: At best: ____/10; At worst: ____/10 (0=no pain, 10= worst/maximal pain)

What intensifies the pain? _____

What alleviates your pain? _____

When did problem begin? _____

List functional limitations/difficulties (tasks during the day at home, work or recreationally)

1. _____ 2. _____ 3. _____

Was this an accident or work related injury? If so, date of accident/injury; describe what happened and where. _____

_____

Have you had this or similar symptoms before? YES NO If yes, please describe:

_____

_____

Please list past surgeries, including minor:

Surgery: Date:

_____

_____

_____

ENDURANCE REHABILITATION

Patient name: _____ Date: _____

Please check any conditions/symptoms listed below that you have had in the past or are currently experiencing:

- ☐ Thyroid problems
- ☐ Hernia
- ☐ Cancer
- ☐ Headaches
- ☐ Migraines
- ☐ Neck stiffness
- ☐ Muscle spasms
- ☐ Muscle cramps
- ☐ Painful joints
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Multiple sclerosis
- ☐ Chills
- ☐ Weakness
- ☐ Dizziness
- ☐ Fatigue
- ☐ Fainting
- ☐ Seizures/Epilepsy
- ☐ Facial pain/numbness
- ☐ Vision deficits
- ☐ Ringing in ears
- ☐ Hearing loss
- ☐ Jaw pain
- ☐ Heat/cold intolerance
- ☐ Poor wound healing
- ☐ Diabetes
- ☐ Circulation problems
- ☐ Kidney problems
- ☐ UTI
- ☐ Asthma
- ☐ Emphysema
- ☐ Pain when breathing
- ☐ Shortness of breath
- ☐ Angina
- ☐ Heart attack
- ☐ High Blood pressure
- ☐ Heart Disease
- ☐ Pacemaker
- ☐ Abnormal Heart beat
- ☐ Stroke
- ☐ Anemia
- ☐ Anxiety
- ☐ Depression
- ☐ Loss of sleep
- ☐ Allergies

For any of the above conditions/symptoms that you marked, please explain:

_____

_____

_____

Please list any medications you are taking:

_____

_____

_____

Are you allergic to latex? YES NO
Are you taking a blood thinner? YES NO
Do you smoke? YES NO

FEMALES
Could you be or are you pregnant? YES NO

I attest that the information provided above is true:

Patient signature: _____ **Date:** _____

Patient Rights & Responsibilities
Consent for Treatment Medical Release

I, _____, hereby authorize Endurance Rehabilitation and/or its licensed medical professionals and such assistants to render any and all medical care deemed necessary and any additional care and supplies that are recommended.

Assignment of Benefits
I authorize Endurance Rehabilitation to process claims related to my personal health or other insurance for covered services rendered to me. I also assign and authorize payment from said insurance carrier to be paid directly to Endurance Rehabilitation rendered on my behalf.

Financial Obligation
Endurance Rehabilitation requires that all co-pays, co-insurances and deductibles be paid at the time of service. Failure to maintain a current patient account may result in the placement of your account with an outside agency for Collection.

Medical Record Release
This will authorize Endurance Rehabilitation to release any general, medical, as well as Psychiatric/Psychological, drug/alcohol, and HIV testing information from my health records, per patient's request.

Third Party Liability
Endurance Rehabilitation does not believe that a liability case against a third party is reason to delay payment of services. I agree that payment for services rendered is not contingent upon any settlement, judgment, or verdict of which they may eventually recover as a result of such liability cases. I agree to be ultimately responsible for payment in full for all services rendered.

Circumstantial Risk
I have been made aware of the possible benefits, effects, and possible risk or complications associated with my care. I agree to accept the treatment prescribed to me and recognize that I am free to seek other opinions relating to my health.

Cancellation/No Show Policy
When canceling your appointment due to scheduling conflicts we ask that you please do so by 4:00 the day prior. In high traffic times we keep a waiting list of patients that would like to have your spot if it is available. If you are unable to cancel your appointment by 4:00 pm the prior day, or if you are unable to make your appointment and do call us, you will be charged a $25 fee.

I have reviewed and understand the Patient History, Patient Rights & Responsibilities, Consent For Treatment, Financial Responsibility, Medical Release, Cancellation/No Show Policy, and HIPAA Privacy Notice. A copy of the aforementioned paperwork will be provided upon request.

Print Patient's Name: _____

_____ _____

Patient or Parent/Guardian Signature **Date**

SERVICES we provide that are NOT typically covered by insurance:

To be cost transparent, we are providing a list of services that are typically NOT covered by insurance. If you have any questions or concerns regarding coverage, please do not hesitate to ask our front office or Practice Manager.

Dry Needling with therapy = $25
Dry Needling without therapy session = $65
Taping Session = $10
Wellness WITH boots= $85
Wellness WITHOUT Boots= $65
Recovery boots ONLY = punch card $90 for 10 or $10 /session
Iontophoresis = $20
Traction ONLY = $25

Supplies (that may be part of treatment session)

Electrical Stim Pads = $5 (MOST COMMON)
Tape Roll (after one prior trial of taping) = $20

We also have various supplies available for purchase (see posting at desk)

Please initial here that you understand that you will be charged for any of the above referenced services or supplies only if you need or request them!

PATIENT INITIALS HERE: _____

Print Name _____ Date _____

Endurance Rehabilitation

CREDIT CARD PAYMENT AUTHORIZATION

The below listed Merchant's card payment software allows for the secure storage of credit card information, through tokenization, for future payments associated with Merchant's health care practice. You authorize charges to your credit card by Endurance Rehab as payment for all products, services, fees and charges under your account. A receipt for each payment will be provided to you via email and the charge will appear on your credit card statement. Should Endurance Rehab or cardholder change the terms of this agreement, including the use of the stored card data or its tokenization practices, below are the contact points.

****YOU ONLY NEED TO FILL OUT THIS FORM IF YOU WOULD LIKE TO KEEP A CARD ON FILE FOR SERVICES PROVIDED. IF YOU PREFER TO BRING YOUR CARD TO EVERY VISIT, YOU MAY SKIP THIS FORM****

Merchant Information

Address: 4440 N 36th Street #240 Phoenix, AZ 85018
Phone #: 602-956-4040

Customer Billing and Contact Information

Billing Address: _____

Phone #: _____

Email: _____

Card Details

- Visa
- Mastercard
- Discover

Patient Name: _____

Cardholder Name: _____

Card Number Ending in (**LAST 4 DIGITS ONLY**): _____/_____/_____/_____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Endurance Rehab in writing of any changes in my account information or termination of this authorization. I acknowledge that the origination of credit card transactions to my account must comply with the provisions of U.S. law and will be used to pay any overdue outstanding invoices for my account. I certify that I am an authorized user of this credit card.

SIGNATURE _____ Date _____