Sunrise Physical Therapy, LLC

Sunrise Physical Therapy, LLC is dedicated to giving each client an individualized, personal service that they can rely on & trust. To help us meet your needs, please fill out this form completely. If you have any questions or need help, please ask, we will be happy to assist you.

Patient Information

Name: Last _____ *First* _____ *MI* _____ *Date* _____/_____/_____

Current address _____

City _____ *State* _____ *Zip* _____

Phone #: H _____ *W* _____ *C* _____

___ *Male* ___ *Female Date of Birth* ____/____/_____ *Age* _____ *E-mail address:* _____

Employer _____ *Occupation* _____

Employer Address _____

City _____ *State* _____ *Zip* _____

Family Doctor _____ *Who can I thank for this referral?* _____

In case of emergency contact: _____

Cancellation / No Show Policy:
If you need to cancel your appointment, please call us ASAP (24 hours notice) so that we have the opportunity to offer your appointment to another patient. If less than 24 hours notice is given or you do not show up, you will be charged for the amount of time you were scheduled at a rate of $125/hour.
Initial _____

Consent for Care and Treatment:
Your physical therapist will complete an evaluation process via interview and examination. From these findings, a treatment plan will then be designed, utilizing a variety of treatment techniques. I, the undersigned, do hereby agree and give consent for Sunrise Physical Therapy, LLC to provide physical therapy care and treatment identified as proper and necessary in addressing my physical condition.
Initial _____

Financial Policy
Sunrise Physical Therapy, LLC accepts payments via cash, check, or credit card (MC/Visa). Services in our office are charged at a rate $125/hr. Discounts are available for prepaid 5, 10, and 15-hour packages. Services at your location are charged at a rate of $195/hr. Foot orthotics are $395 all inclusive. We ask for full payment to be rendered at the time of service. We will be happy to provide you with forms for submission to your insurance company for possible reimbursement.

I agree that the information above is accurate. I understand the terms of this form and realize that I am financially responsible for charges incurred from cancellations or no shows.

Patient Name: _____ Date: _____/_____/_____

Patient Signature: _____

Medical History- Sunrise Physical Therapy, LLC

Do you:

Smoke: No____ Yes_____ Yrs____ Packs/day____
Drink diet soft drinks: No____ Yes_____ Drinks/day_____
Use artificial sweeteners: No____ Yes_____
Take Statin drugs (cholesterol lowering): No____ Yes_____
Sleep with pillow under/between knees: No____ Yes_____
Sleep well and wake up rested: No____ Yes_____ Hours of sleep_____
Wake up stiff in the morning: No____ Yes_____
Eat tomatoes, potatoes, peppers, eggplant: No____ Yes_____
Exercise: No____ Yes_____
Type and amount: _____

How many ounces of water a day do you drink: _____ How much coffee/tea _____
Stress level, 0 being none, 10 the worst: ___0 ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10
Pain level, 0 being none, 10 the worst: ___0 ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10

Current symptoms/problem area: _____
_____
_____
Current medications: _____
_____
Current supplements: _____
_____
Allergies to drugs, food, or other items (including latex): _____
_____
Operations/surgeries/fractures/significant injuries: (even as child) and year: _____
_____
_____
_____
_____

Please check if you have had, or have, any of the following conditions:

___ Insomnia	____ High blood pressure	____ PTSD	____ Phobias _____
___ Arthritis	____ Mental illness/Depression	____ Stroke	____ High cholesterol
___ Eating disorder	____ Candida	____ Cancer	____ Diabetes (type I or II)
___ Brain injury	____ Heart attack/Disease	____ Asthma	____ Celiac disease
___ Migraines	____ Thyroid dysfunction	____ Pacemaker	____ Shortness of breath
___ Alcoholism	____ Heart palpitations	____ Dizziness	____ Irritable bowel syndrome
___ Blood clots	____ Multiple chemical sensitivity	____ Alcoholism	____ Chronic fatigue syndrome
___ Substance abuse	____ Restless leg syndrome	____ Reflux	____ Carbon monoxide poisoning
___ Fibromyalgia	____ Difficulty swallowing	____ Diarrhea	____ ADD ____ ADHD
___ Lyme's disease	____ Difficulty speaking	____ Concussion	____ Sleep disorders
___ Anxiety	____ Intrusive thoughts	____ Stuttering	____ Empty nest syndrome
___ Sleep apnea	____ Miscarriage	____ Ulcers	____ Sweaty hands and feet
___ Night sweats	____ Hemorrhoids	____ Headaches	____ Crohn's disease

Other conditions not listed: _____

Patient Name: _____ Date: _____

Patient Signature: _____

Sunrise Physical Therapy, LLC

Notice of Health Information Practices

This notice describes how information about patients may be used and disclosed and how patients can get access to this information. Please review it carefully.

1. Introduction

Sunrise Physical Therapy, LLC is committed to treating and using personal health information about all our patients responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes patient rights as they relate to personal health information. This applies to all personal health information as defined by federal regulations.

2. Understanding Health Records/Information

Each time a patient visits Sunrise Physical Therapy, LLC, a record of the visit is made. Typically, this record contains symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as the health or medical record, can possibly serve as a:

* Basis for planning care and treatment,
* Means of communication among the many health professionals who contribute to the care,
* Legal document describing the care received,
* Means by which you or a third-party payer can verify that services billed were actually provided,
* A tool in educating health professionals,
* A source of data for medical research,
* A source of information for public health officials charged with improving the health of this state and the nation,
* A source of data for our planning and marketing,
* A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

3. Your Health Information Rights

Although your health record is the physical property of Sunrise Physical Therapy, LLC, the information belongs to you. You have the right to:

Obtain a paper copy of this notice of information practices upon request,
Inspect and copy the health record (a reasonable fee may be required),
Request an amendment of the health record,
Obtain a list of the disclosures of the health information,
Request a restriction on certain uses and disclosures of your information and,
Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

4. Our Responsibilities

Sunrise Physical Therapy, LLC is required to:

Maintain the privacy of the health information,
Provide patients with this notice as to your legal duties and privacy practices with respect to information that we collect and maintain,
Abide by the terms of this notice,
Notify the patients if we are unable to agree to a requested restriction.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will provide the updated policy at the time of a future visit.

Patient Name: _____

Patient Signature: _____ Date: _____