NEXT LEVEL
PHYSICAL THERAPY & PERFORMANCE INC

Patient Information

Please print clearly and complete all sections. If you have any questions, please ask the receptionist.

Patient Name: _____ (First / Middle / Last) Email: _____

Date of Birth: _____ Age: _____ Sex: Male: ❑ Female: ❑

Address: _____ (Street / City / State / Zip)

Phone Number: ( ) - _____ (Primary) ( ) - _____ (Secondary)

Parent/Guardian: _____ (If patient is a minor / Name) _____ (Emergency Contact Relationship to Patient)

Emergency Contact: _____ (Name) _____ (Emergency Contact Phone Number)

Referring Provider: _____ (Name) _____ (Injury/ Pain)

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

ID/Member #: _____ ID/Member #: _____

Group#: _____ Group#: _____

If patient is not the plan subscriber, please complete below

Subscriber Name: _____ Subscriber Name: _____

Subscriber Date of Birth: _____ Subscriber Date of Birth: _____

Relationship to patient: _____ Relationship to patient: _____

Claim Information

Worker's Compensation or Motor Vehicle Accident Only

Worker's Compensation	Motor Vehicle Accident
Employer:	Insurance:
Employer Address:	Claim #
Date of Injury:	Date of Injury:
Claim Number:	Claim Address:
Claims Manger:	Claims Adjuster:
Have you had any previous physical therapy visits on this claim? Yes❑ No❑	Phone Number:

Who can we thank for telling you about Next Level Physical Therapy? _____

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Statement of Privacy Practices

We at Next Level Physical Therapy & Performance Inc. are dedicated to protecting the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices, but we will always inform you of any changes that might affect your rights.

Protecting Your Personal Health Care Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act (HIPAA) and the state of Arizona. This includes issues relating to your treatment, payment, and our physical therapy operations. Your personal health information will never be otherwise given to anyone-even family members-without your written consent. You, of course, may give written authorization for us to disclose your information to anyone that you choose, for any purpose.

Our office and electronic systems are secure from unauthorized access, and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients. Therefore, you can be confident that your protected health care information will never be improperly disclosed or released.

Collecting Protected Health Care Information

We will only request personal information needed to provide our standard of physical therapy care, implement payment activities, conduct normal physical therapy operations, and comply with the law. This may include your name, address, telephone number(s), social security number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information for third parties if deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of Your Protected Health Care Information

As stated above, we may disclose information as required by law. We are obligated, under certain circumstances, to provide information to law enforcement and government officials. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments. This would include voicemail messages, answering machines, e-mail or text message reminders, and phone calls.

Patient Rights

You have a right to request copies of your health care information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services. A full, detailed copy of our privacy practices and your rights are available upon request and are posted in our front office.

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Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Next Level Physical Therapy & Performance Inc. Next Level Physical Therapy & Performance Inc. reserves the right to change the privacy practices that are described in the Statement of Privacy Practices . If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the first available opportunity. I may also request a revised statement be mailed to me.

Printed Name: _____

Signature: _____

Relationship to Patient: _____

Date Received: _____

Your Protected Health Information Designees

If you are not available when we attempt to contact you, please list below those individuals with whom we can leave a message or briefly discuss your medical information (e.g. appointments, payment information, etc.).
This person will also be able to call the office on your behalf.

Please print the name and relationship (to the patient) of each designee below.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

❑ Check here if you **do not want** your health care information discussed with anyone but yourself.

Record of Acknowledgement Not Obtained

For Office Use Only

We attempted to obtain written acknowledgement of patient's receipt of our Statement of Privacy Practices, but acknowledgement could not be obtained from the patient for the following reason:

- ❑ Patient needed more time to review the Statement of Privacy Practices
- ❑ Patient wanted to consult with another person before signing
- ❑ Patient refused to sign
- ❑ Patient is unable to sign
- ❑ Other (explain) _____

Was prior treatment provided? ❑ Yes ❑ No

Date any prior treatment was provided: _____

Employee Signature: Date:

NEXT LEVEL
PHYSICAL THERAPY & PERFORMANCE INC

PATIENT NAME: _____ D.O.B. _____/_____/_____

PRIMARY	SECONDARY
Insurance: _____	Insurance: _____
Subscriber: _____	Subscriber: _____
ID #: _____	ID #: _____
Group # _____	Group # _____
Coverage: _____	Coverage: _____
Deductible: _____	Deductible: _____
Ded Met: _____	Ded Met: _____
Visit Max: _____ yr _____ cond	Visit Max: _____ yr _____ cond
Out of Pocket: _____	Out of Pocket: _____
OOP Met: _____	OOP Met: _____
Co Pay: _____ per visit	Co Pay: _____ per visit
Pre Auth: _____ Yes _____ No	Pre Auth: _____ Yes _____ No
Auth #: _____	Auth #: _____
Auth Date: _____	Auth Date: _____
Claim #: _____	Claim #: _____

Next Level Physical Therapy has informed me of my insurance benefits to the best of their knowledge. **I understand that it is my responsibility to know in advance whether or not my insurance will pay for physical therapy and what my medical benefits are.**

Signature: _____ Date: _____/_____/_____

I authorize my insurance benefits to be paid directly to Next Level Physical Therapy. I understand I am responsible for any balance due. I also authorize the release of any medical information necessary to process this claim. I understand that I am financially responsible for all charges for services rendered regardless of litigation, insurance reimbursement, pending worker's compensation claims or MVA liens. The parent or guardian accompanying a minor for treatment will be responsible for payment. I understand that in some instances the applicable insurance does not cover the entire charge. I agree to be responsible for any portion of the bill not covered by insurance. I understand that if my account has an outstanding balance over 90 days duration, I will be charged a 1% per month finance charge unless other arrangements are made in writing with Next Level Physical Therapy & Performance Inc.

Signature: _____ Date: _____/_____/_____

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PHYSICAL THERAPY & PERFORMANCE INC

Financial Policy

We'd like to thank you for choosing Next Level Physical Therapy for your physical therapy treatment.
In order for us to bill your insurance company on a regular basis, we request that you sign this release of information and assignment of benefits (if applicable). Typically, insurance companies pay a predetermined percentage of our treatment charge. We therefore request that on each visit you pay the difference and/or any applicable co-payments. This will enable you to keep your account current and avoid a large balance that may be difficult for you to pay in one payment at the end of your treatment.
All accounts not covered by insurance are due and payable in full at the time of service. We accept cash, checks, and credit/debit cards. If needed, you may apply for an extended payment plan upon approval of credit.

Regarding Insurance

Your insurance policy is a contract between you and your insurance company. We cannot accept responsibility for collecting an insurance claim or negotiating a disputed claim. However, we can and will help by submitting your claim for you. The balance for services rendered at Next Level Physical Therapy & Performance Inc. is your financial responsibility.

I have read and understand: _____
Initials

Late Cancellations and No-Shows

We understand that sometimes the unexpected can happen, and you may be unable to keep an appointment. **We request a 24 hours notice prior to canceling or rescheduling an appointment. If a patient fails to give proper notice, a $65 no show/cancel fee will be implemented.** This fee can not be billed to insurance and will be the resposibility of the patient at the next visit. **If you reschedule the missed appointment within the same week, the fee will be waived.**

I have read and understand: _____
Initials

I authorize my insurance benefits to be paid directly to Next Level Physical Therapy & Performance Inc. and I understand that I am financially responsible for any balance due. I also authorize the release of any medical information necessary to process this claim.
I understand that I am financially responsible for all charges for services rendered regardless of litigation, insurance reimbursement, or pending worker's compensation claims. I understand the parent or guardian accompanying a minor for treatment will be responsible for payment.

I understand that in some instances the applicable insurance does not cover the entire charge. I agree to be responsible for any portion of the bill not covered by insurance. I understand that if my account has an outstanding balance over 90 days duration, I will be charged a 1% per month finance charge unless other arrangements are made in writing with Next Level Physical Therapy & Performance Inc..

I hereby consent to the performance of physical therapy measures prescribed by my referring provider. I hereby waive and release Next Level Physcial Therapy & Performance Inc., their agents or employees from any and all claims, costs, expenses, liabilities, or judgments including attorney's fees and court costs (herein collectively "claims") arising out of my/my dependent's participation in the Next Level Physcial Therapy & Performance Inc.'s treatment or any illness or injury resulting therefrom.

I further agree to indemnify and hold harmless Next Level Physical Therapy & Performance Inc., their agents or employees from and against any and such claims except claims caused by gross neglect or willful misconduct.

If a patient is a minor, and in the event I cannot be reached in an emergency, I hereby give my permission to the physician selected by Next Level Physical Therapy & Performance Inc. to administer emergency care.

I acknowledge that I have read and understand the financial policy and the cancellation and no-show policy stated above. I consent to have treatment by Next Level Physcial Therapy and Performance Inc. I certify that all information I have provided in this registration form is true and correct to the best of my knowledge.

_____ _____
Signature of Patient or Responsible Party Date

NEXT LEVEL
PHYSICAL THERAPY & PERFORMANCE INC

No-Show / Cancellation Policy

Please Read Carefully

Effective 1/1/2022

We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable, however, advanced notification allows us to fulfill other patient's scheduling needs and keeps the clinic operating at its most efficient level. Due to the one-on-one treatment with the therapist, missed appointments are a significant disruption to the clinic and other patient's care.

1. Please provide our office with at least **24 hours notice** to cancel an appointment. Patients who do not attend a scheduled appointment or do not provide proper notice will be responsible for a **$65.00** office visit charge. **This charge can not be billed to insurance.**
2. Patients who reschedule a missed appointment within the same Monday through Friday week, will have their fee waived.
3. Insurances, accident claims, and worker's compensation payors expect regular attendance to physical therapy as a requirement of medical necessity. If appointments are missed, it could affect how visits are processed and the payment of your claims.
4. Your treatment plan has been carefully crafted by your practitioners to help you get back to your regular activities as quickly as possible. Missing appointments hinders that process and may end up prolonging recovery time.

Thank you for your understanding. Signing below indicates you understand and agree to our policy.

Signature of patient/responsible party _____

Printed name _____ Date _____

NEXT LEVEL
PHYSICAL THERAPY & PERFORMANCE INC

Patient Name: _____ **Height:** _____ **Weight:** _____
Surgeon /Referring Doctor: _____
Date of Onset of Pain: _____ **Date of Injury:** _____ **Date of Surgery:** _____ ☐ New Injury ☐ Chronic
What is your primary concern? _____
Pain Location: _____ **Treatment Side:** ☐ N/A ☐ Left ☐ Right

Pain Scale: 0= None 5= Moderate 10= Extreme

	0	1	2	3	4	5	6	7	8	9	10
At worst:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Current:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
At best:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Aggravating Factors: ☐ Sitting ☐ Standing ☐ Walking ☐ Lying down/Sleeping ☐ Stairs
☐ Reaching ☐Lifting ☐ Getting up from a chair ☐ Bending forward ☐ Carrying heavy objects

What makes it feel better? _____ **Feel worse?** _____
History of Similar Symptoms: ☐ No ☐ Yes **History of Falls in last year:** ☐ No ☐ Yes
Home Health Care: ☐ No ☐ Yes **Hospitalization in last 3 months?** ☐ No ☐ Yes
Occupation: _____

Medical History:

☐ Alzheimer's	☐ Fracture or Suspected Fracture	☐ Rheumatoid Arthritis
☐ Cardiovascular Disease	☐ High Blood Pressure	☐ Traumatic Brain Injury
☐ Cauda Equina Syndrome	☐ History of Cancer	☐ Allergies: _____
☐ CVA / Stroke	☐ Huntington's	☐ Unexplained Weight Loss
☐ Current Infection	☐ Immunosuppression	☐ Pacemaker
☐ Diabetes Mellitus Type 1	☐ Lupus	☐ Pregnant
☐ Diabetes Mellitus Type 2	☐ Muscle Dystrophy	☐ Seizures
☐ Hemophilia	☐ Osteoarthritis	☐ HIV/AIDS
	☐ Hepatitis B/C	☐ Other: _____

Diagnostics: ☐ X-Ray ☐ MRI ☐ CT Scan ☐ Myelogram ☐ Diagnostic Ultrasound
Results of Imaging: _____
Medications: ☐ See attached _____
_____
Patient Goals for Physical Therapy: _____

Patient Signature _____ **Date** _____

REVIEW OF SYSTEMS: *Please mark the appropriate 'NO' lines, or provide details*

NO		DETAILS
___	General (e.g. fever or chills, poor general health, unexplained weight loss, fatigue)	_____
___	Skin (e.g. rashes, new skin lesions, or a change in moles)	_____
___	Eyes (e.g. blurred vision, or change in visual acuity)	_____
___	Ears (e.g. ear pain, or difficulty hearing)	_____
___	Nose (e.g. nasal congestion, discharge, or bleeding)	_____
___	Mouth/Throat (e.g. sore throat or difficulty swallowing)	_____
___	Respiratory (e.g. shortness of breath, cough, wheezing)	_____
___	Cardiovascular (e.g. high/low blood pressure, palpitations)	_____
___	Gastrointestinal (e.g. nausea, vomiting, diarrhea, constipation, abdominal pain, discolored stools)	_____
___	Genitourinary (e.g. problems initiating or controlling my bladder, or have problems with urinary frequency)	_____
___	Endocrine (e.g. heat or cold intolerance, weight loss or gain, increasing thirst)	_____
___	Hemato-Immunologic (e.g. bruise easily, bleeding)	_____
___	Psychiatric (e.g. depression, anxiety, suicidal thoughts or attempts)	_____

I verify the above information is complete and accurate.

_____ _____

Patient or Guardian Date

PATIENT NAME: _____ **ID#:** _____ **DATE:** _____

Description: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability.

Please circle the answers below that best apply

Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

Pelvic Floor Distress Inventory Questionnaire - Short Form 20

			If yes, how much does it bother you?			
			Not at all	Somewhat	Moderately	Quite a bit
1.	Do you usually experience pressure in the lower abdomen?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
2.	Do you usually experience heaviness or dullness in the lower abdomen?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
3.	Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
4.	Do you usually have to push on the vagina or around the rectum to have a complete bowel movement?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
5.	Do you usually experience a feeling of incomplete bladder emptying?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
6.	Do you ever have to push up in the vaginal area with your fingers to start or complete urination?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
7.	Do you feel you need to strain too hard to have a bowel movement?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
8.	Do you feel you have not completely emptied your bowels at the end of a bowel movement?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
9.	Do you usually lose stool beyond your control if your stool is well formed?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
10.	Do you usually lose stool beyond your control if you stool is loose or liquid?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
11.	Do you usually lose gas from the rectum beyond your control?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)

12.	Do you usually have pain when you pass your stool?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
13.	Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
14.	Does part of your stool ever pass through the rectum and bulge outside during or after a bowel movement?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
15.	Do you usually experience frequent urination?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
16.	Do you usually experience urine leakage associated with a feeling of urgency; that is, a strong sensation of needing to go to the bathroom?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
17.	Do you usually experience urine leakage related to laughing, coughing, or sneezing?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
18.	Do you usually experience small amounts of urine leakage (that is, drops)?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
19.	Do you usually experience difficulty emptying your bladder?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
20.	Do you usually experience pain of discomfort in the lower abdomen or genital region?	☐ No (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)

Therapist Only

ICD9 Code: _____

Comorbidities:

☐ Cancer
☐ Diabetes
☐ Fibromyalgia
☐ Obesity
☐ Heart Condition
☐ High Blood Pressure
☐ Multiple Treatment Areas
☐ Surgery for this Problem

Barber MD, Walters MD, Bump RC. Short forms of two condition-specific quality-of-life questionnaires for women with pelvic floor disorders (PFDI-20 adn PFIQ-7). Am J Obstet Gynecol 2005;193:103-113.