FAST TRACK PHYSICAL THERAPY & SPORTS MEDICINE

6717 S. 900 E., Suite 201
Midvale, UT 84047-5755
Phone: (801) 649-4690
Fax: (801) 984-4011

PATIENT INFORMATION:

Name: _____ Date: _____

Address: _____ City:_____ State: _____ Zip: _____

SSN: _____

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone: (_____)_____

Email: _____ Best Way to Contact (circle): Home / Work / Cell / Email

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ Marital Status: _____

Work Status (circle): full-time / part-time / retired / student / homemaker / not employed currently

Occupation: _____ Major Job Requirement(s): _____

MEDICAL INFORMATION:

Referring Individual/Physician: _____ Date Last Seen: _____

Primary Care Physician: _____

How did you hear about Fast Track? _____

Reason for P.T. Today: _____ Date of Onset: _____ Diagnosis: _____

Did this Injury happen at Work? YES / NO Was this a Motor Vehicle Accident?: YES / NO

Surgery Date: _____ How Injury Occurred: _____

Diagnostic Test(s) Performed (X-ray, MRI, etc) and Results: _____

Previous Treatment for this Injury? YES / NO If so, Please List and Date: _____

Please List any/all Medical/Health Problems: _____

_____

Goal in Coming to P.T.: _____

Please provide a current list of medications, including: prescriptions, over-the-counter medications, and herbal medications, as well as vitamin/mineral/dietary (nutritional) supplements. Dosage, frequency (times/day or week) and route of administration (oral, injection, etc.)

_____

_____

_____

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PAIN QUESTIONNAIRE

Please Circle the Number Below that Best Corresponds with Your Pain Level.
Please Circle One Number Below for Each of the Following: NOW / AT WORST / AT BEST

(Please indicate "N" / "W"/" B")

No Pain *Worst Pain Possible*

0 1 2 3 4 5 6 7 8 9 10

Please Indicate if the Following Activities Increase (↑), Decrease (↓), or do not Change (=) Your Pain:

Sitting: _____ Standing: _____ Walking: _____ Laying on Back: _____ Laying on Stomach: _____
Coughing: _____ Sneezing: _____ Voiding: _____ Up/Down Stairs: _____ Bending: _____
Other (Please List): _____

Please Chose the Symptoms that Best Describe Your Pain (circle all that apply):

Sharp Dull Achy Numbness Burning Tingling Shooting

Constant Intermittent Other (Please Describe):_____

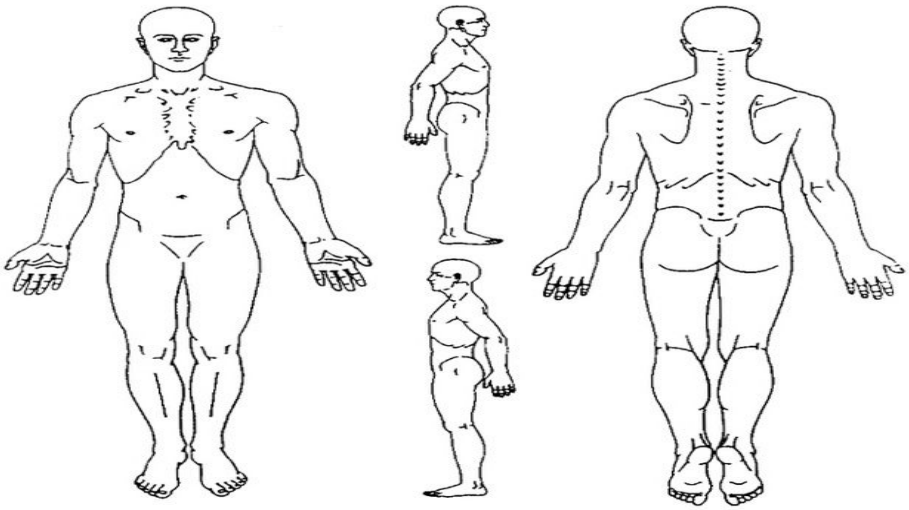
Do you have pain that wakes you up at night: YES / NO If so, is it related to your position: YES / NO

Any changes in bowel or bladder function recently: YES / NO If so, please describe: _____

What percent are you limited because of this injury in your normal daily activities (0 – 100%):_____

What activities are you limited in doing because of this injury: _____

Please identify the location(s) of your symptoms (pain, numbness, etc) on the



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PRIVACY NOTICE

In agreeing to receive care provided by Fast Track Physical Therapy and Sports Medicine PLLC ("Fast Track") located at 6717 South 900 East Suite 201, Midvale, Utah, 84047, I agree as follows:

I understand that in order to meet the legal requirements of the Health Insurance Portability and Accountability Act ("HIPPA"), Fast Track requires my consent to release information from my medical and insurance records as appropriate to my medical needs, including but not limited to, chart notes, surgery reports, X-Ray and MRI reports, medical history, diagnoses, insurance coverage, payment history and demographic information, such as my social security number. This release authorizes the above types of information to be released in written, electronic and oral formats as necessary for my medical needs, insurance requirements and payments to my account.

I further understand and agree that Fast Track providers and staff will do everything possible to keep my medical, personal and insurance information private and will release only what is necessary to provide exceptional medical care and customer service. On occasion, legal requests are made for copies of patient records. When and if this occurs, Fast Track will abide by any court order or subpoena to provide such information. I understand that I have the right under HIPPA to examine and request copies of and changes to my medical records and to request restrictions on the uses and disclosures of my personal health information.

Name (print) _____ Date: _____

Signature (Patient/Parent/Guardian of patient) _____

Name of person signing on behalf of patient (print) _____

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WAIVER AND RELEASE OF LIABILITY

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I fully understand and acknowledge that (a) the activities in which I will engage, as part of the treatment provided by Fast Track and the physical therapy activities, and equipment I may use as a part of that treatment have inherent risks and dangers and are potentially dangerous activities; (b) my participation in such activities and/or use of such equipment may result in serious bodily injury. By my participation in these activities, I hereby accept the responsibility and assume all risks and dangers for any harm, injury or damage whether caused in whole or in part by the negligence or the conduct of the representatives or employees of Fast Track, or by any other person.

I, on behalf of myself, my personal representatives and my heirs, hereby voluntarily agree to release, waive, discharge, hold harmless, defend and indemnify Fast Track Physical Therapy and Sports Medicine, PLLC and its representatives, employees and assigns from any and all claims, actions or losses for bodily injury, property damage, wrongful death, loss of services or otherwise which may arise out of my use of any equipment or participation in physical therapy activities, whether the result of negligence or any cause. I voluntarily and knowingly acknowledge, accept and assume these risks.

I HAVE READ THE ABOVE WAIVER AND RELEASE AND BY SIGNING IT AGREE TO COMPLETELY RELEASE AND RELIEVE FAST TRACK FROM ANY LIABILITY FOR INJURY, PROPERTY DAMAGE OR WRONGFUL DEATH CAUSED BY NEGLIGENCE OR ANY OTHER CAUSE.

Patient Name (print): _____ Date: _____

Signature (Patient/Parent/Guardian of Minor): _____

Name of Person Signing on Behalf of Patient (print): _____

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PAYMENT AGREEMENT

In agreeing to receive care provided by Fast Track Physical Therapy and Sports Medicine, PLLC ("Fast Track") located at 6717 South 900 East Suite 201, Midvale, UT 84047, I agree as follows:

I agree that I will pay Fast Track $_____ per physical therapy session, as a co-pay, co-insurance payment, or private pay. Accordingly, I choose the following option for my physical therapy services.

Please initial next to the option you would like to use for primary coverage of your physical therapy services

_____ Health Insurance *

_____ Medicare (Please initial if Medicare is your primary insurance)

_____ Workers' Compensation

_____ Auto Insurance **

_____ Private Pay *** ($120.00 Initial Exam & $100.00 each follow up appointment)

_____ Other (Accident Insurance other than auto or workers' compensation)

I authorize the payment of medical benefits to Fast Track. I also authorize the release of any necessary information to process my insurance claim.

I understand that Fast Track will bill my insurance company as a courtesy, if indicated above; however, I understand and agree that I am financially responsible for any/all charges even if insurance is pending or denies my claim(s) – regardless of reason(s) given by my insurance company. I further understand that any applicable co-pay, or co-insurance is due at the time of service and that Fast Track will bill me for any amounts not covered under my health insurance benefits. I agree to pay the invoiced amount within thirty (days) of receipt of invoice. Any unpaid balance past that time will be considered delinquent and accrue at a rate of ten (10%) percent, monthly.

I understand that if I need to cancel or reschedule my appointment at Fast Track, I will notify Fast Track no later than twenty-four (24) hours prior to the scheduled appointment. I further understand that failure to provide this notice will result in a forty ($40) cancellation charge that will be assessed on my next invoice and/or due prior to my subsequent visit.

* I understand and agree that I am responsible for knowing and verifying my insurance benefits for physical therapy services and satisfying all deductible, co-pay, or co-insurance amounts according to my insurance plan(s) – payable to Fast Track.

** I understand that by choosing my auto insurance as my payment method, I will still be personally responsible for any and all charges not reimbursed by my insurance company. For that reason, we will need to keep a copy of your personal health insurance card on file for when/if your auto (PIP) benefits are exhausted. I agree to allow Fast Track to bill my personal health insurance if the above circumstance arises.

*** If you have elected Private Pay as your payment method to Fast Track, please ask the front office staff for our Payment Plan Set-up Agreement.

Name (printed) _____ Date: _____

Name (signature) _____

Consent to Photograph, Video, or Record Form

Requesting Organization: Fast Track Physical Therapy and Sports Medicine, PLLC

Address: 6717 South 900 East, Suite 201

City, State, Zip code: Midvale, Utah 84047

Phone: 801-649-4690

I, _____, a current patient at/of Fast Track Physical Therapy and Sports Medicine

Hereby authorize the above organization to:

(Check all that apply)

- ☐ Photograph me
- ☐ Video me
- ☐ Record my voice

I also grant Fast Track Physical Therapy and Sport Medicine the right to edit, use and reuse said products for non-profit purposes including in print, on the internet, and all other forms of media. I also hereby release Fast Track Physical Therapy and Sports Medicine and employees from all claims, demands, and liabilities whatsoever in connection with the above.

Signature of Parent/Guardian (Under 18): _____ Date: _____
Address of Parent/Guardian: _____

OR

Signature of Patient (Over 18): _____ Date: _____
Address of patient: _____