Basic Healing Physical Therapy
9017 S Pecos Rd., Suite 4500 Henderson, NV 89074
Phone: (702) 277-6269 Fax: (702) 778-5800

Patient Demographics

Name : ___________________________________ Date of Birth____________ Gender M F

Address: ____

Phone # ____________________________ Email: ____________________________________

Emergency Contact Name ____________________________ Phone (____) _____-__________

Social Security # _______-_____-________

Insurance Information

Primary Insurance: _____________________________(If Lein or Workers Compensation, write insurance carrier.)

ID# ___________________________ Insurance Phone # (_____)______-________

Secondary Insurance: (Circle if applicable) AARP BCBS Other

ID# ____________________________ Insurance Phone # (_____)______-________

No Fault & Workers Compensation Information

Circle: *Lein* *Workers Comp.* Date of Accident _____/_____/________

Attorney's name _____________________________ Phone # (____) _____-_________

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Patient Questionnaire

Today's Date:__________________

Patient Name:______________________________Date of Birth: _____________Phone: _________________

Referring Physician: ____Phone: ____________________

HISTORY OF PAIN:

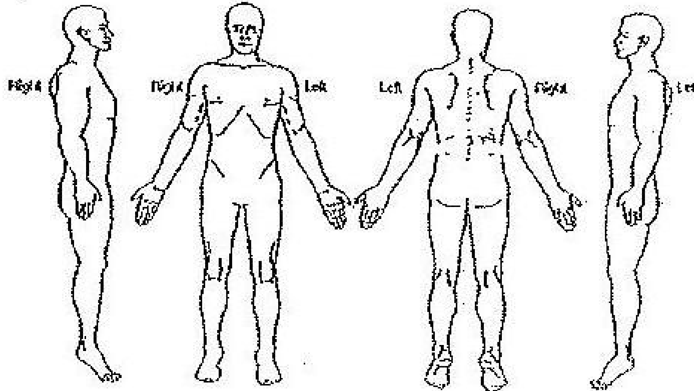
1. What is the main complaint for which you are seeking treatment?

   ____

2. What caused your pain to start? How long have you had the pain/problem you are currently experiencing?

   ____

3. On the diagram below, shade the areas where you feel pain. Put an "X" on the area that hurts most.



4. Please **circle** the level of your pain on a scale of 0 to 10. (0= no pain; 10= worst imaginable pain)

   0 1 2 3 4 5 6 7 8 9 10

5. What type of pain do you have? (Check the box that best describes your pain.)

   ☐ Aching ☐ Cramping ☐ Shooting ☐ Throbbing ☐ Burning ☐ Numbness ☐ Stabbing
   ☐ Sharp ☐
   Other____

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PAST MEDICAL HISTORY:

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

- ☐ Obesity
- ☐ Cancer
- ☐ Heart Problems
- ☐ High blood pressure
- ☐ Asthma, Emphysema
- ☐ Sensation changes
- ☐ Current Infection
- ☐ Diabetes
- ☐ Depression
- ☐ Seizures
- ☐ Peripheral Neuropathy
- ☐ Osteoarthritis /penia
- ☐ Fractures
- ☐ Stroke
- ☐ HIV
- ☐ Fibromyalgia
- ☐ Vertigo
- ☐ Pacemaker
- ☐ Bowel or Bladder
- ☐ Other Conditions

PAST SURGICAL HISTORY:

Date	Procedure

FAMILY HISTORY: (Check all that apply)

- ☐ High blood pressure
- ☐ Hepatitis
- ☐ Diabetes
- ☐ Depression
- ☐ Cancer
- ☐ Heart Attack
- ☐ Asthma
- ☐ Seizures
- ☐ Schizophrenia
- ☐ Thyroid disease
- ☐ Heart Disease
- ☐ Lupus
- ☐ Multiple Sclerosis
- ☐ Alcoholism
- ☐ Bleeding disorder
- ☐ Other

____

MEDICATIONS:____

DIAGNOSTIC STUDIES:

Test	Date	Body Part	Facility Where Test Was Done
X-rays			
MRI			

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Consent Form/ Reimbursement Agreement

Patient Name: ____

Consent to Evaluate and Treat

I do hereby consent to the evaluation and treatment by Basic Healing Physical Therapy. I understand it is my right to accept or refuse any treatment offered to me. I acknowledge and understand that no guarantee has been made to me as to the results that may be obtained from such treatment.

Assignment of Benefits

I request that payment of the Medicare/Other Insurance benefits be made on my behalf for any services furnished to me by Basic Healing Physical Therapy. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Financial Agreement

The undersigned agrees, whether signing as an agent or a patient, that s/he individually obligates him/herself to pay for services rendered in accordance with the rates and terms of Basic Healing Physical Therapy or a previously agreed upon payment plan. If the patient's insurance policy should become inactive or should coverage changed in any way during the treatment, s/he understands it is her/his responsibility to notify Basic Healing Physical Therapy immediately. Any treatment not covered by insurance becomes the responsibility of the patient.

The undersigned is aware that should s/he directly receive a claim payment from the patient's insurance company, it is her/his responsibility to forward ALL explanation of benefits alone with any checks received to the provider (Basic Healing Physical Therapy)

I understand that if I do not have supplemental insurance I will be responsible for the twenty percent (20%) co-insurance portion not paid by Medicare as well as my deductible.

I also understand that if I am currently enrolled in a home health episode, the treatment I receive at Basic Healing Physical Therapy may be denied by Medicare and I will be liable for the payment of services.

The undersigned certifies that s/he has read, understood and accepts the terms of this form, received a copy, and is the patient or is authorized by the patient as a general agent to execute this form.

______________________________________ ______________________

Signature of Patient or Authorized Representative **Date**

______________________________________ ______________________

Printed Name **Relationship to Patient**

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APPOINTMENT AND PROCEDURE CANCELLATION POLICY

This document informs the undersigned patient (the "Patient") of the appointment and procedure cancellation policies of Basic Healing, LLC a Professional Corporation doing business as Basic Healing Physical Therapy. By signing this document, Patient indicates that he or she has read, understood, and agreed to the policies contained in this document as a condition of receiving treatment, care, services, or any kind of procedures from Basic Healing Physical Therapy (Basic Healing).

Basic Healing offers a unique and valuable health care experience for its patients. Because some courses of treatment last for multiple visits, Basic Healing must plan well in advance to devote the necessary time and resources to providing each of its patients the appropriate care and attention they deserve. Thus, it is incumbent on Patient to honor all previously scheduled appointments with Basic Healing, as doing so is in the interests of Basic Healing, Patient, and other patients of Basic Healing.

Basic Healing requires Patient to cancel or re-schedule any appointment, treatment, service, procedure, or other visit to Basic Healing **at least** 24 hours in advance. Basic Healing generally will schedule any treatment, procedure, service, appointment, visit, or other reason for Patient to come to Basic Healing far enough in advance that Patient will be able to provide a 24 hour advance notice of the need to cancel or re-schedule Patient's appointment, treatment, service, procedure, or any other visit to Basic Healing; notwithstanding the foregoing, if Basic Healing schedules Patient for any appointment, treatment, service, procedure, or other visit to Basic Healing less than 24 hours from the time of scheduling, Patient is expected to provide as much notice of cancellation or re-scheduling as possible. To cancel or re-schedule any visit, Patient must call Basic Healing by calling **702-277-6269**. Patient must speak to a receptionist or other representative of Basic Healing to re-schedule or cancel the appointment and ensure that Patient will not be subject to any fees, as specified below, for missing or untimely canceling or re-scheduling an appointment. **Simply leaving a message for Basic Healing will not be sufficient to cancel or re-schedule your appointment; you must speak to a Basic Healing representative**.

Patient understands and agrees that if patient misses or untimely re-schedules any appointment, treatment, service, procedure, or other visit to Basic Healing without providing at least 24 hours of advanced notice to Basic Healing, then Basic Healing shall charge Patient **$25.00** for each such missed, untimely re-scheduled, or late-cancelled appointment, treatment, service, procedure, or any other visit. Patient further understands and agrees that Basic Healing may take any measures it deems necessary to collect this cancellation charge, including but not limited to invoicing Patient, charging Patient's debit or credit card on file, including the cancellation charge on Patient's next invoice or amount due to Basic Healing, and taking any collection action Basic Healing deems prudent and necessary for the collection of the cancellation fee.

______________________________ ____________________
Patient Signature Date

____
Patient Name (Print)

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CREDIT CARD AUTHORIZATION FORM

PATIENT NAME: ____ Date:____/____/____

Cardholder Name: ____

Cardholder Signature: ____

Billing Address: ____

Telephone Number: ___________________________________

Credit Card Type: _____ VISA _____ MASTERCARD ____ DISCOVER _____ AMEX

Credit Card Number: ________ - ________ - ________ - ________

Expiration Date: ________ / ________

Card Identification Number (last 3 digits located on the back of the credit card): __________

Amount Charged: $ ________________ (USD)

FAX or send the authorization to:

Larry Flisser, PT
Basic Healing, LLC Physical Therapy
9017 S. Pecos Rd, Suite #4555
Henderson, NV 89074
Office: 702-277-6269
Fax: 702-778-5800

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Mutual Binding Arbitration Agreement

Patient Name: ____ Date of Birth: ___________________

This mutual binding arbitrary agreement constitutes an integral part of the contract for medical services by and between Basic Healing, LLC and (Patient Name)_____________________________ who agree to be bound as described hereunder.

1. It is understood that any dispute as to medical malpractice, that is, as to whether any medical services rendered under this Contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided in Nevada Law, and not by lawsuit or resort to court process except as Nevada law provides for judicial review of arbitration proceedings. Both parties to this Contract, by entering into it, are giving up the constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

2. Such arbitration shall be in accordance with the arbitration rules of the Nevada Revised Statutes. This Mutual Binding Arbitration Agreement shall apply to any legal claim or civil action in connection with any and all medical care or medical services rendered against Basic Healing or any of Basic Healing's employees or contracted staff.

3. The execution of this Mutual Binding Agreement shall not be precondition of the furnishing of medical services of Basic Healing. This Mutual Binding Arbitration Agreement may be rescinded by written notice from the Patient or Patient's legal representative within 30 days of signature.

4. The Mutual Binding Arbitration Agreement shall bind the parties hereto, including the heirs, representatives, executors, administrators, successors, and assigns of such parties.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Date: ___________________Time: ___________________________ A.M. / P.M.

Printed Name: _______________________________________ Signature: ________________________