



1526 Idylwild Dr., Ste A
Prescott, AZ 86305

Office Phone Number: (928) 442-1234

Office Fax Number: (928) 442-1351

Welcome!!

Dear Patient

Garcia Physical Therapy would like to welcome you to our clinic!

Thank you for choosing us as your rehabilitation provider. We know you will be extremely satisfied with the quality of care and individual attention we provide to all of our patients.

During the first visit your therapist, Sylvia will perform a comprehensive evaluation, develop a plan of care and begin a treatment program based on your test results and goals. Please plan on a full hour for each appointment.

To keep the focus on you and your health care needs we ask you to please:

- 1 Arrive 15 minutes early.
- 2 Wear or bring comfortable workout clothing.
- 3 Bring medical insurance cards.
- 4 Bring physician's prescription for physical therapy.
- 5 Bring completed forms. (Don't forget the goals section!)
- 6 **We accept Cash, Check, Visa and MasterCard for any co-payments or self payment.**
- 7 **As a courtesy to employees and other patients please refrain from wearing strongly scented perfumes and lotions as they may cause distress to scent sensitive individuals.**
- 8 **We would like to achieve the most out of each of your appointments that you have scheduled with Sylvia please help us to maximize your therapy by turning off electronic devices that may distract yourself, the therapist or other patients.**

We are committed to your satisfaction and returning you to a healthier and more active lifestyle.

Very Truly Yours,

Maria Sylvia Garcia, PT, MOMT &
the staff of Garcia Physical Therapy

Garcia Physical Therapy

Name: _____

▶ I hereby authorize Garcia Physical Therapy, LLC and/or the representative to provide physical therapy treatment which is considered necessary and proper in diagnosing and treating my child or myself.

▶ I hereby authorize release of information required by insurance carriers and treating physicians concerning illness and treatment of the above named patient.

I understand that I am responsible for all incurred charges. Garcia Physical Therapy, LLC may submit charges to my insurance company(s) on my behalf, however, I am responsible for any payment(s) should my insurance claim be denied.

▶ I understand and agree that if I fail to make payment(s) within 30 days of receiving invoice, I will be held responsible for any and all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees, etc.

▶ A copy of the Privacy Practice has been made available to me from Garcia Physical Therapy, LLC. A copy is posted in the lobby. I hereby authorize Garcia Physical Therapy, LLC and/or the representatives to discuss my medical care and/or accounting information with the persons listed below. I may revoke this at any time by giving written notification to Garcia Physical Therapy, LLC.

May we leave messages regarding appointments at your home? Yes _____ No _____

(Examples: Husband/ Wife, Son/ Daughter, Significant other, answering machine Etc.)

Emergency Contact Information

Print Name	Phone Number	Date of Birth	Relationship
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Print Name	Phone Number	Date of Birth	Relationship
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Print Name	Phone Number	Date of Birth	Relationship
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Print Name	Phone Number	Date of Birth	Relationship
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Patient / Guardian Signature

Date

Garcia Physical Therapy

PATIENT FINANCIAL RESPONSIBILITY

Patient Name: _____

Please read and initial the following statements:

I understand that I am responsible for all incurred charges. Garcia Physical Therapy, LLC may submit charges to my insurance company(s) on my behalf, however, I am responsible for any payment(s) should my insurance claim be denied.

I understand and agree that if I fail to make payment(s) within 30 days of receiving invoice, I will be held responsible for any and all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees, etc.

I understand that it is my responsibility and not that of Garcia Physical Therapy, LLC to contact my insurance company(s) to obtain my physical therapy benefits including co-insurance, deductible, and limitations. I further understand that no statement made by a representative of Garcia Physical Therapy, LLC is guarantee of my insurance benefits or coverage.

_____ **Co-Payment:** _____ **Due at Date of Service** **Please note we accept cash, check, Visa or Master Card**

_____ **Deductible met per Ins** _____ **of** _____ **Co-Insurance per Visit** _____

(This is an estimate based on your individual insurance and may be subject to change)

ATTENDANCE POLICY

In order to receive maximum benefit from physical therapy, it is important that you follow the treatment plan prescribed by your physician. You and your therapist will decide on a schedule for your therapy. It is important to attend all sessions on a regular basis. Please read and initial the following statements.

We ask that you **give 24 hours notice** if you need to cancel or reschedule your appointments.

Please be advised that 2 no shows, or 2 cancellations, with less than 24 hour notice, may result in discharge from physical therapy.

I understand I will be charged \$20.00, which will be collected at the next appointment, for no show or cancellation of appointments with less than 24 hours notice. (This charge cannot be applied to insurance benefits.)

Thank you for your cooperation and understanding.

_____ **Patient/Guardian Signature**

_____ **Date**

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Please fill in all fields if there is something that does not apply please put N/A

Name: _____ Age: _____ Referring Physician: _____
 Family Physician: _____ Date of 1st Dr. visit for this injury/condition: _____
 Employer: _____ Job Title: _____
 Job Duties: _____

Last date worked due to this injury/condition: _____ Date returned to work after this injury/condition: _____
 Date of onset of symptoms/injury: _____ Injury type: Auto _____ Work related _____
 Other _____ Describe injury: _____

Have you had surgery for this injury/condition: YES ___ NO ___ Number of surgeries: _____
 Type of surgery: _____ Date of surgery: _____

What are your rehabilitation goals while in this physical therapy program?
 1 _____
 2 _____
 3 _____

Are you currently taking any prescription or non-prescription medications: YES ___ NO ___
 Anti-inflammatories: _____ Muscle relaxers: _____ Pain Medication: _____
 List medications: _____

Are you allergic to any medications: YES ___ NO ___ List Medications: _____

Have you had any of the following medical or rehabilitative services for this injury/episode?

	YES	NO		YES	NO	When	Where
Chiropractor	___	___	Occupational Therapy	___	___		
General Practitioner	___	___	Physical Therapy	___	___		
Massage Therapy	___	___	X-Rays	___	___		
Neurologist	___	___	CT Scan	___	___	_____	_____
Orthopedist	___	___	MRI	___	___	_____	_____
Podiatrist	___	___	Emergency Room Care	___	___	_____	_____
Other	___	___		___	___		

Do you now have or have you ever had ANY of the following?

	YES	NO		YES	NO		YES	NO
Do you have a Pacemaker	___	___	Emphysema	___	___	Varicose Veins	___	___
Diabetes	___	___	Shortness of Breath	___	___	Epilepsy/Seizures	___	___
Cancer	___	___	Chest Pain	___	___	Allergies	___	___
Chemotherapy/Radiation	___	___	Vision/Hearing Difficulties	___	___	Thyroid Disease or Goiter	___	___
Any Pins/Metal Implants	___	___	Coronary Heart Disease	___	___	Anemia	___	___
Joint Replacement Surgery	___	___	Angina	___	___	Infectious Diseases	___	___
Neck Injury/Surgery	___	___	Dizziness or Fainting	___	___	Arthritis	___	___
Shoulder Injury/Surgery	___	___	High Blood Pressure	___	___	Osteoporosis	___	___
Elbow/Hand Injury/Surgery	___	___	Bowel or Bladder Problems	___	___	Gout	___	___
Back Injury/Surgery	___	___	Heart Attack or Surgery	___	___	Emotional/Psychological Problems	___	___
Knee Injury/Surgery	___	___	Weakness	___	___	Severe/Frequent Headaches	___	___
Leg/Ankle/Foot Injury/Surgery	___	___	Stroke / TIA	___	___	Weight Loss	___	___
Are you pregnant?	___	___	Congestive Heart Disease	___	___	Energy Problems	___	___
Do you use tobacco?	___	___	Hernia	___	___	Sleeping Problems/Difficulties	___	___
Asthma, Bronchitis	___	___	Blood Clot/Emboli	___	___			
Allergies other than medications:								

List any other information that would assist us in your care: _____
 Patient / Guardian Signature: _____ Date: _____
 Patient / Guardian Printed Name: _____

Garcia Physical Therapy

Pain Chart

Patient Name: _____

Date: _____

Indicate where you are having pain and circle amount of pain on graph.

Right Left Right Left Right Left

0-No Pain 2-Mild, Annoying 4-Uncomfortable 6-Miserable 8-Horrible 10-Extreme