Physical Therapy New Patient Demographics

Today's Date:_______________________________

Primary Care Physician: ______________________________ Ph: ________________ Fax: _______________

Your Name: ____ Gender: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other:________________________________

Social Security Number: ________-________-________ Date of Birth:__________________ Age _______

Mailing Address:____

City/State/Zip:____

Employer:______________________________________ Occupation: ________________________________

Your Email Address: ____

Daytime Phone # ____________________________________ ☐ Home ☐ Mobile ☐ Work

Emergency Contact Name: _______________________________Relationship:________________________

Phone Number: __________________________________ Phone Type: ☐ Home ☐ Work ☐ Cell

How did you hear about us?

☐ Insurance Co ☐ Employer ☐ Facebook ☐Instagram

☐ Linkd In ☐ Internet Search ☐ Family/Friend ☐ Other: ___________________________

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Sun Pain Management, PLLC or insurance company to release any information required to process my claims.

____ ___________________

Signature of Patient or Legal Representative Date

____ ___________________

Patient or Legal Representative Name (Printed) Date

HIPAA Medical Release Authorization

Authorization for use or disclosure of health information

I ____ authorize Sun Pain Management use or disclose the following information.

_____ All of my medical-related information

_____ My medical information related to ____________________________________.

To release any and all patient medical and billing information to any physician involved in my treatment; to any health care facility to which I/the patient is discharged or transferred for treatment; to affiliates of Sun Pain Management for purposes of treatment, billing, quality assurance, collections, or defense of litigation or anticipated litigation; and to any insurance company, review organization or other entity, which is directly or indirectly responsible for payment or review of services provided by Sun Pain Management. I consent to use and disclosure of my protected health information to carry out treatment, payment or healthcare operations by the clinic and by affiliates of Sun Pain Management.

I understand information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) and other communicable diseases, genetic testing, Developmental/Behavioral Health/Psychiatric Care, and treatment of alcohol and/or drug abuse. My signature authorizes such a release as indicated above. I understand that the information disclosed by this authorization may be subject to redisclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996 or other applicable federal and state law. I understand that if I agree to sign this authorization, I may keep a signed copy of the form. I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. However, if my treatment is related to my participation in a research study, I understand that I may be refused treatment if I do not sign this authorization.

I have read and understood the terms of this authorization, and I have had a chance to ask questions about the use or disclosure of my health information. I authorize the named entity above to use or disclose my health information in the manner described above.

Patient Signature: ____________________________________Date: ____________

Witness:____Date:____________

Sun Pain Management Administration Policies

Privacy Notice and Bill of Rights

Sun Pain Management complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I acknowledge I have received the Notice of Privacy Practices and Patients' Bill of Rights.

Signature of Patient or Guardian: __________________________Date: ____________

INFORMED CONSENT FOR PHYSICAL THERAPY EVALUATION AND TREATMENT

At Sun Pain Management, PLLC, we are committed to providing patient-centered care that addresses your physical function, pain management, and overall mobility. Physical therapy (PT) is an essential component of rehabilitation, aimed at improving your strength, movement, and quality of life. This consent outlines the nature of these services, the roles of the professionals involved, and your rights and responsibilities as a participant in care.

NATURE AND PURPOSE OF SERVICES

Physical therapy services include, but are not limited to, a comprehensive diagnostic evaluation, therapeutic exercise, manual therapy techniques (joint mobilization, soft tissue work), functional training, pain management modalities (heat, ice, electrical stimulation), and individualized home exercise programs. You are being asked to provide informed consent to participate in physical therapy, which is recommended to treat your current functional limitations, injury, or pain.

PROVIDERS INVOLVED IN CARE

Your care may be provided, supervised, or coordinated by a multidisciplinary team of licensed professionals, including:

- Licensed Physical Therapists (PT/DPT)
- Licensed Physical Therapist Assistants (PTA)
- Physical Therapy Aides/Technicians (operating under direct supervision)
- Student Interns enrolled in accredited Physical Therapy programs or affiliated college programs, operating under the direct supervision of a licensed PT.

COORDINATION OF CARE

Our physical therapy team works in close collaboration with your referring physicians, pain management providers, and/or other healthcare providers to ensure integrated, holistic treatment. You understand that your clinical information, including evaluation findings and progress notes, may be shared internally among the treatment team at Sun Pain Management, PLLC, and/or any other "Doing Business As" (DBA) subsidiaries for the purposes of care coordination, unless you request otherwise.

CONFIDENTIALITY AND LIMITS

All services provided are confidential and in compliance with the Health Insurance Portability and Accountability Act (HIPAA), state laws, and applicable licensing board regulations. Your treatment information will not be shared without your written consent except in cases where disclosure is required by law, such as:

- If there is reason to believe you are at risk of harming yourself or others.
- If there is suspected abuse or neglect of a child, elderly, or vulnerable adult.
- If ordered by a court or regulatory agency.

RISKS AND BENEFITS

Physical therapy frequently involves physical exertion and movement. While intended to improve your condition, there are inherent risks, including but not limited to: increased temporary pain, muscle soreness, fatigue, or rare occurrences of strain/sprain. However, physical therapy has been shown to provide significant benefits, including improved mobility, reduced pain, increased strength, and improved quality of life.

VOLUNTARY PARTICIPATION

Your participation in physical therapy is voluntary, and you have the right to accept or decline any part of the treatment at any time. Declining services may affect the outcome of your recovery. You may request to discontinue services or seek a referral to another provider at any time.

ACKNOWLEDGEMENT AND CONSENT

By signing below, you acknowledge that you have read, understand, and voluntarily consent to receive physical therapy services as outlined above. You understand the roles of the care providers involved, the scope and limits of confidentiality, the risks and benefits of treatment, and your right to discontinue treatment at any time.

Print Name:

DOB:

Patient Signature:

Date:

SUN PAIN MANAGEMENT FINANCIAL POLICY

As a courtesy, Sun Pain Management ("SPM") verifies benefits with your insurance company. A quote of benefits is never a guarantee of payment. Your insurance company will process your claims according to your Plan Document. If you do not have a copy of your Plan Document you should obtain one as soon as possible, read and understand this contract between you and your insurance company. Should your claims process differently from any estimate you were quoted, your Plan Document will supersede any other information given verbally or in writing from the Practice.

If your Plan Document includes Pain Management benefits, we will be happy to bill your insurance. Please provide a current copy of your insurance card to the front office staff. When your insurance claim(s) are processed, you will receive an Explanation of Benefit/Payment from your insurance company. This Explanation will advise your financial responsibility for treatment. You will be held responsible for any unpaid balances by your insurance plan.

CONSENT TO BILL, ASSIGNMENT OF BENEFITS, AND PAYMENT I authorize Sun Pain Management and any of its 3rd party billing associates to file a claim with my insurance carrier for services rendered. I authorize SPM payment of benefits directly to SPM, for services provided to myself me. I understand that I am responsible for any part of the charges that are not covered/paid by my insurance, and I will be billed directly for those services

Should your insurance company pay you directly for services rendered by our practice or affiliates, you agree to endorse and return all monies to this practice within 7 days of receipt.

1. **PAYMENT** - is expected at the time of your visit. (This includes Copayments, Deductibles, Coinsurance, Missed Appointments, Procedure Prepayment; unpaid balance after insurance has paid their portion, Past Due balances, etc). If you are unable to meet your financial responsibility, Sun Pain reserves the right to reschedule your appointment to a later date when you can meet your financial responsibility. If a prepayment is made for any services and a refund is due after your insurance pays, any outstanding balance on your account will be deducted before issuing your refund. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount or non-covered charges from your insurance company. If you do not have insurance or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit. We require a copy of an ID card and/or license and insurance cards.
2. **INSURANCE** - We are participating providers with several insurance plans. A list of these insurance plans is available upon request. If we submit your claims and your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment from your insurer, we will refund any overpayment to you. If our doctors are not listed in your plan's network, you may be responsible for payment. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to call your insurance about your benefits prior to your appointment. We are not responsible for any erroneous information listed on insurance websites and do not guarantee your coverage. You are responsible for obtaining a properly dated referral, prior authorization (if required) from your insurer and responsible for payment if your claim rejects for the lack of specific requirements. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you are responsible for all charges. Payment is due upon receipt of a statement from our office. All procedures billed are considered covered unless limited by your specific insurance policy. If your coverage changes and you have not notified us of these changes in writing and we bill your old carrier, we may miss the time limit to receive payment. In this case, the claim becomes your responsibility for payment. Please notify us immediately if your coverage changes so we can submit your claims for appropriate reimbursement.
3. **COLLECTION** - If you have an outstanding balance over 120 days old and have failed to make payment arrangements or fall delinquent on an existing payment plan, we may turn your balance over to a collection agency and/or an attorney. This may result in reporting to credit bureaus and/or legal action. Sun Pain reserves the right to refuse treatment to patients with outstanding balances over 120 days old. You are responsible for any expenses we incur to

collect on your account including attorney fees, collection fees, and/or contingent fees to collection agencies that can be more than 35% of the delinquent balance. Contingency fees will be added to your balance and assigned to the collection agency immediately upon your account being assigned to a collection agency of our choice. You agree that for us to service your account or to collect any amounts you may owe, we may contact you by phone at any number associated with your account including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded voice messages and/or use of an automatic dialing device.________ initials

4. **RETURNED CHECKS** - Will incur a $40.00 service charge. You will be asked to bring cash, certified funds, or a money order to cover the amount of the check plus the $40.00 service charge to pay the balance prior to receiving any future services from our staff or the physicians. Stop payments or overturned chargebacks on your credit card constitute a breach of payment and are subject to the $40.00 service fee and collections action. All bad checks written to this office are subject to collections and will be prosecuted by the governing laws in Maricopa County.
5. **ACCOUNTING PRINCIPALS** - Payment and credits are applied to the oldest charges first, except for insurance payments, which are applied to the corresponding dates of service.
6. **FORMS AND CONSULT FEES** - Completing insurance forms, copying medical records, etc... requires office staff time and time away from patient care for our doctors. We require pre-payment for completing forms, copying medical records, notarizing or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter or communication. On occasion, our staff may be asked to provide a deposition and/or other testimony or actions concerning your care. There is a separate fee schedule for such activity. The fees for such activity are to be paid by the patient regardless of the party requesting the activity.
7. **CARE COORDINATION** - Care coordination billing includes clinical staff time per calendar month and is delivered under the overall direction of the billing practitioner. Cost sharing applies for both face-to face and non-face-to-face services even if supplemental insurers cover cost sharing. ______ Initials
8. **CANCELLATIONS OR MISSED APPOINTMENTS** - If you do not cancel your appointment at least 24 hours in advance or if you no-show, we will assess a $25.00 missed appointment fee. If you do not cancel your procedure with at least 24 hours' notice, you will be assessed a $25.00 missed procedure fee. Multiple no-shows/missed procedures may result in your formal discharge from the practice. Initials ________
9. **RESPONSIBILITY FOR PAYMENT** - I understand that I personally am financially responsible to Sun Pain for charges not covered by the assignment of insurance benefits. Initials _______
10. **ASSIGNMENT OF INSURANCE BENEFITS** - I hereby assign, transfer, and set over directly to Sun Pain sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said practice. I authorize Sun Pain to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Sun Pain. I authorize Sun Pain to release all medical information requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.
11. **RELEASE OF INFORMATION** - I hereby authorize the and direct Sun Pain to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.
12. **AGREEMENT AND UNDERSTANDING:** I have read and understand the practice's financial policy of Sun Pain and I agree to be bound by its terms. I understand that I am financially responsible for ALL services I receive from Sun Pain. I hereby assign all medical and surgical benefits and authorize my insurance carrier (s) to issue payment directly to Sun Pain. This financial policy is binding upon me, my estate, executors and/or administrators, if applicable. I also understand and agree that such terms may be amended by the practice from time to time and I may be asked to read, understand, and sign any updates.

Signature of Patient or Guardian: ____________________________________ Date: ________________

Witnessed by: ____ Date:________________

CONSENT TO RECEIVE SERVICES VIA TELEHEALTH

This form provides information about the use of telehealth as a mode of service delivery and documents your consent to participate in medical, behavioral health, psychiatric, or care coordination services via secure, HIPAA-compliant remote communication technologies.

What is Telehealth?

Telehealth is the use of interactive, secure audio, video, and/or electronic communication to deliver healthcare services when you and your provider are not in the same physical location. At Sun Pain Management, PLLC, this includes services provided by pain management clinicians, physical therapists, psychiatric mental health nurse practitioners (PMHNPs), licensed behavioral health professionals, and care coordinators.

Telehealth may be used for, but is not limited to, psychiatric medication management, individual or group therapy, behavioral health assessments, follow-up and check-in appointments, care coordination, or case management.

Telehealth may be used for, but is not limited to, physical therapy exercise, therapeutic activities, neuromuscular re-education, functional training, patient instruction and safety, follow-up and check-in appointments, care coordination, or case management.

Confidentiality and Security

All telehealth sessions are conducted through HIPAA-compliant platforms. Reasonable and appropriate efforts are made to protect the security and confidentiality of your information, including the use of encryption, secure servers, and password-protected systems. However, just as with in-person care, there is always a risk of unauthorized access or technical failure that could compromise privacy. You are responsible for ensuring privacy on your end of the telehealth session (e.g., using a private space, securing your device, and refraining from using public Wi-Fi during sessions).

Risk and Limitations of Telehealth

While telehealth offers many advantages, including increased access to care, it has limitations, such as potential for service disruption due to technological issues (e.g., poor internet connection, platform failure), limited ability for providers to respond to certain medical or psychiatric emergencies remotely, possible difficulty interpreting body language or non-verbal cues, and risk of data breaches if proper cybersecurity practices are not followed by the patient

If technical difficulties prevent the completion of a session, your provider will attempt to contact you via phone or reschedule as appropriate.

Emergency and Crisis Protocols

Telehealth is not appropriate for crisis situations requiring immediate intervention. If you are experiencing a medical or psychiatric emergency, you must call 911 or go to the nearest emergency room.

You are required to provide your physical location and a reliable contact number at the start of each session and identify an emergency contact and/or local emergency services available in your area.

If a provider determines that you are at risk of harm to yourself or others during a telehealth session, they may initiate emergency services or wellness checks, consistent with clinic policy and professional responsibilities.

Consent and Voluntary Participation

Your participation in telehealth is voluntary. You may choose to decline or withdraw consent at any time without affecting your access to in-person services (when available and applicable). You have the right to:

- Ask questions about the telehealth process
- Request alternative methods of communication if appropriate

- Receive a copy of this consent form upon request

By signing below, you acknowledge that you have read and understand the information provided above. You consent to receive services via telehealth, including evaluation, diagnosis, treatment, and follow-up. You understand the risks, benefits, and limitations of telehealth You authorize Sun Pain Management, PLLC to use telehealth technologies in the course of your care.

____

Print Name:

____

Patient Signature:

____

DOB:

____

Date:

Consent to Release Protected Health Information

Patient Name: ________________________________ DOB: ______________ Date: ____________

Initials__________	I authorize Sun Pain Management to use/disclose my personal health information to the individual(s) listed on this form.
Initials__________	I understand that Sun Pain Management staff may leave detailed messages on my voicemail.

1. Contact Name: ***(Emergency Contact)***			
Phone:		*Phone (other):*	
Address:			
Relationship: ☐Spouse ☐Family (describe)____________________ ☐Friend ☐Other (describe)_________________			
2. Contact Name:			
Phone:		*Phone (other):*	
Address:			
Relationship: ☐Spouse ☐Family (describe)____________________ ☐Friend ☐Other (describe)_________________			
3. **Contact Name:**			
Phone:		*Phone (other):*	
Address:			
Relationship: ☐Spouse ☐Family (describe)____________________ ☐Friend ☐Other (describe)_________________			

I hereby authorize Sun Pain Management to use and disclose my personal health information to the individuals identified on this form.
I understand this authorization does not expire unless written notice is mailed to 11047 N 19th Ave, Phoenix, AZ 85029 to the attention of the Practice Administrator.
I understand this may include information relating to communicable diseases, such as HIV/AIDS, sexually transmitted diseases, behavioral or mental health, alcohol and/or drug abuse treatment, and genetic testing information, if any records exist.
I understand that the individuals identified on this form will be treated by Sun Pain Management as individuals involved directly in my care and as such, Sun Pain Management will be allowed to release my personal health information to these individuals and additionally for the purposes of treatment, payment, and healthcare operations to include the request of medical records from/to any other healthcare providers and/or institutions.
I understand that I have a right to request and receive a Notice of Privacy Practices from Sun Pain Management.
I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as the original.
I voluntarily sign this authorization, and I understand that my ability to obtain health care from Sun Pain Management will not be affected if I refuse to sign this authorization.

Patient Signature: ____ Date: ______________________

Personal Representative Signature: ____ Date: ______________________

Relationship to Patient: ____

11047 N 19th Ave
Phoenix, AZ 85029
Phone: 602-589-0500
Fax: 602-314-4552

MEDICAL RECORDS REQUEST

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

PATIENT'S NAME: ____**DOB:** ____________________________________

PREVIOUS NAME: ____

TO RELEASE HEALTHCARE INFORMATION OF THE PATIENT FROM:

NAME: ____ **ADDRESS:** ________________________________

PHONE: ____ **FAX:** _____________________________________

I REQUEST MY MEDICAL RECORDS BE SENT TO:

SUN PAIN MANAGEMENT
SECURE FAX: 602-314-4552

TYPE OF INFORMATION TO BE DISCLOSE:
OFFICE VISITS
XRAYS/MRI'S/ CT REPORTS/ EMG REPORTS
PERTINENT LAB REPORTS
HISTORY AND PHYSICAL
CONSULTATION REPORTS __ BEHAVIORAL HEALTH
CURRENT MEDICATIONS __ SUBSTANCE ABUSE

DATE RANGE TO RELEASE (Please choose one):
__ ALL
__ LAST 2 YEARS
__ DATE RANGE: _________________

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ________________. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

PATIENTS SIGNATURE: ____**DATE:** ____________________________________

The Documents in this facsimile transmission may contain confidential health information that is privileged and legally protected from disclosure by Federal Law; the Health Insurance Portability Act (HIPAA). This information is intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, you are hereby notified that any reading, disseminating, distributing, copying, acting upon or otherwise using the information contained in this facsimile is strictly prohibited. If you have received this error, please immediately notify the sender by telephone and facsimile. Thank you.

SUN
PAIN MANAGEMENT
& SPINE SPECIALISTS

Medical Information

Please answer all questions as COMPLETELY as possible. An incomplete form may delay your medical treatment.

____ ______________
Last Name First Name Middle Initial DOB

Please mark the area of your pain on the diagram:

Past Medical History:
Please check the box if you had, or currently have, any of the following medial conditions (Listed are examples and not a complete list of possible conditions):

Head/Neck: ☐ Headaches ☐Sinusitis ☐Tinnitus ☐Other________________________________
Heart: ☐ Pace Maker ☐ Coronary Artery Disease ☐ Heart Attack ☐ Chest Pain
Lungs: ☐ Emphysema ☐ Chronic Bronchitis ☐ COPD ☐ Asthma ☐ Other________________
Kidney: ☐ Stones ☐ Insufficiency ☐ Cysts ☐ Pain ☐ Other ________________________
Liver: ☐ Cirrhosis ☐ Hepatitis ☐ Fatty ☐ Other ________________________________
Digestion: ☐ GERD ☐ Peptic Ulcer Disease ☐ Diarrhea ☐ Constipation ☐ Pain ☐ Other____________
Muscles/Bones: ☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Other ____________________
Skin/Breasts: ☐ Psoriasis ☐ Skin Cancer ☐ Fibrocystic Disease ☐ Other ________________
Nervous System: ☐ Stroke ☐ TIA ☐ Seizures ☐ Multiple Sclerosis ☐ Other ______________
Psychological: ☐ Anxiety ☐ Depression ☐ Bipolar ☐ Schizophrenia ☐ Other ______________
Blood System: ☐ Anemia ☐ Hemophilia ☐ Clotting ☐ Other ________________________
Endocrine: ☐ Diabetes ☐ Cushing ☐ Addison ☐ Other ____________________________
Immune System: ☐ HIV ☐ AIDS ☐ Infections ☐ Other ______________________________
Any Other: ____

Medications: (Check here if you attached a copy of your medication list ☐)

Name of Medication	Strength	# of Pills Per Day	Date Last Prescribed

Past Surgical History/Implants:

Date:	Type:	Date:	Type:
________	____________________	________	____________________
________	____________________	________	____________________
________	____________________	________	____________________