AVALA PHYSICIAN NETWORK

PATIENT INFORMATION

Patient Name **Social Security Number**	**Home Telephone #**_____ **Cell Telephone #** _____
Address	**Patient Sex**
City, State & Zip Code	**Date of Birth**_____
FOR MEDICARE PATIENTS ONLY Do you currently reside in a Skilled Nursing Facility? ☐ Yes ☐ No	**Emergency Contact Name & Phone** **Relationship to Patient:**
Employment/ Student Status: ☐ Full time employed ☐ Full time student ☐ Part time employed ☐ Part time student ☐ Unemployed ☐ Retired	**Employer Name & Address** **Occupation:**
Email Address (please print):	☐ Single ☐ Married ☐ Other
Ethnicity of Patient: ☐ Hispanic Origin ☐ Non-Hispanic Origin ☐ Unknown ☐ Declined to Answer **Patient's preferred language:** ☐ English ☐ Spanish ☐ Other:	**Race of Patient:** ☐ American Indian/ Alaskan Native ☐ Asian ☐ Black/ African American ☐ Native Hawaiian/ Other Pacific Islander ☐ White ☐ Unknown ☐ Declined to answer
In compliance with the American Recovery and Reinvestment Act of 2009 **(ARRA)** to demonstrate Meaningful Use, we are required to capture demographic data including your preferred language, race and ethnicity.	

Financially Responsible Person (if different from above)

Full Name	Social Security Number
Address	Home Telephone#
City, State & Zip Code	Cell Telephone#
Date of Birth	
Employer Name	Relationship to the patient: ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other

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Insurance Company Information

Primary Insurance Company Name	**Secondary Insurance Company Name**
Policy Number **Group Number**	**Policy Number** **Group Number**

Self-Pay? ☐ **YES** ☐ **NO**

Insurance Authorization and Assignment of Benefits

I certify that the information that I have reported with regards to my insurance coverage is correct. I also authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits to AVALA, for anesthesia and orthopedic surgical services provided to me. I fully understand that payment for services is not contingent upon recovery, and this does not relieve me of my primary obligation to pay.

Signature: _____ Date: _____

Medicare Patients

If you are covered by Medicare, please read, and sign the following:

In Medicare cases, AVALA, agrees to accept the charge determination of Medicare as the full charge, and the patient is responsible only for deductible, co-insurance, and non-covered services. Coinsurance and the deductibles are based upon the charge determination of Medicare.

Signature: _____ Date: _____

ePrescribing

ePrescribing is a federally mandated initiative that requires all physicians prescribe in this manner by 2011. ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information. ePrescribing software also lets your doctor see important information - like drug interactions and your prescription history.

The benefit to you:

>Less confusion over handwritten prescriptions or unclear phone calls

>Reduced possibility of medical errors

>Less chance of adverse drug reactions

>Fewer trips to drop off at the pharmacy

>A safer, faster, easier way to get your prescription filled

>

Patient Consent: I agree that AVALA may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

_____ _____

Patient's Signature Date

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Patient Medical History

Name:_____ **Date:** _____

Birthdate: _____ Height: _____ Weight: _____

Referring Physician: _____ Primary Care: _____

Cardiologist: _____ Pulmonologist: _____

Rheumatologist: _____ Pain Management: _____

CHIEF COMPLAINT

Why are you seeing the doctor today? _____

_____

Have you had treatment for this problem before? ☐ Yes ☐ No

Date symptoms began? _____

Is this problem the result of (check all that apply)

☐ Car Accident ☐ Work Accident ☐ Other: (please specify) _____

Are you left/right hand dominant? ☐ Right ☐ Left
Are you/could you be pregnant? ☐ Yes ☐ No
Do you exercise/play sports? ☐ Yes ☐ No Type/Frequency _____

Pharmacy Name: _____ **Location:** _____ **Phone Number:** _____

ALLERGIES Please describe any current or past allergic reactions ☐ I have no allergies

Drug Allergy	Reaction	Treatment for Reaction

Medication History:

***List the names of ALL medications that you take with or without a prescription**

Name of Medication	Dosage	Reason for Taking

Social History

Do you smoke? ☐ Current ☐ Former ☐ Never

How long have you smoked? _____ # Est. packs per year: _____

Do you chew tobacco? ☐ Yes ☐ No Do you use E-cigarettes or vape? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No How many drinks a month? _____

Do you have a history of drug/alcohol abuse? ☐ Yes ☐ No

Family History

Please check the box of all of the following problems your blood relatives (i.e. parents, sibling, grandparent) have had:

☐ Alzheimer's
☐ Arthritis Type_____
☐ Cancer Type_____
☐ Other_____
☐ Diabetes
☐ Gout
☐ Heart Disease
☐ Osteoporosis
☐ Stroke
☐ Sudden Death

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PAST MEDICAL HISTORY: (Please Check Any/All of the Following that Apply)

☐ Anemia	☐ Diabetes	☐ Kidney Dysfunction	☐ Pulmonary Embolism
☐ Arthritis Type _____	☐ DVT/Blood Clots	☐ Kidney Dialysis	☐ Rheumatic Fever
☐ Asthma	☐ Epilepsy	☐ Liver Disease	☐ STD
☐ Birth Defects	☐ Gallbladder Problems	☐ Lung Problems	☐ Stroke/TIA
☐ Bladder Problems	☐ Gout	☐ Phlebitis	☐ Tuberculosis
☐ Bleeding/Bruising	☐ Heart Disease	☐ MRSA/Staph Infection	☐ Thyroid Problem
☐ Cancer Type _____	☐ Hepatitis	☐ Osteoporosis	☐ Ulcers Type _____
☐ Colon Polyp	☐ HIV/AIDS	☐ Peripheral Vascular Disease	
☐ Congestive Heart Disease	☐ High Blood Pressure	☐ Polio	
☐ COPD/Emphysema	☐ High Cholesterol	☐ Psychological Problems	
☐ Depression	☐ Irritable Bowel Syndrome	☐ Pulmonary Embolism	

☐ **Other:** _____

Past Surgical History

Previous Surgeries	Hospital	Year
☐ Arthroscopy		
☐ Joint Replacement		
☐ Bone/Joint Reconstruction		
☐ Spine		
☐ Trigger Finger Release		
☐ Carpal Tunnel Release		
☐ Other Surgery/Hospital Stay		
☐ Previous Steroid Injections		
☐ I have not had surgery or been hospitalized		

REVIEW OF SYSTEMS

Please check any/all you have experienced in the past month. Be sure to notify your doctor if you have experienced any of the following.

General	Gastrointestinal	Eyes	Cardiovascular
☐ Fever/Chills	☐ Abdominal Pain	☐ Glasses/Contacts	☐ Chest Pain
☐ Weight Change	☐ Heartburn/Acid Relief	☐ Cataracts	☐ Palpitations
☐ Hormone problems	☐ Constipation	☐ Glaucoma	☐ Fluid/Swelling in Extremities
☐ Other	☐ Diarrhea	☐ Other	☐ Other
☐ None	☐ Nausea	☐ None	☐ None
	☐ Vomiting		
Respiratory	☐ Other	**ENT/Mouth**	**Endocrine**
☐ Shortness of breath	☐ None	☐ Difficulty Swallowing	☐ Painful Urination
☐ Sleep Apnea		☐ Ear Pain	☐ Frequent Urination
☐ Wheezing	**Neurological**	☐ Seasonal Allergies	☐ Incontinence
☐ Other	☐ Headaches	☐ Hard of Hearing	☐ Other
☐ None	☐ Numbness	☐ Other	☐ None
	☐ Tingling	☐ None	
Hematologic/Lymphatic	☐ Seizures		**Psychological**
☐ Anemia	☐ Weakness	**Skin**	☐ Anxiety
☐ Blood Problems	☐ Other	☐ Rashes	☐ Depression
☐ Clotting Disorder	☐ None	☐ Lumps	☐ Mood Swings
☐ Lymph Problems		☐ Other	☐ Other
☐ Other	**Musculoskeletal**	☐ None	☐ None
☐ None	☐ Back Pain		
	☐ Neck Pain		
	☐ Joint Pain		
	☐ Joint Swelling		
	☐ Decreased Range of Motion		

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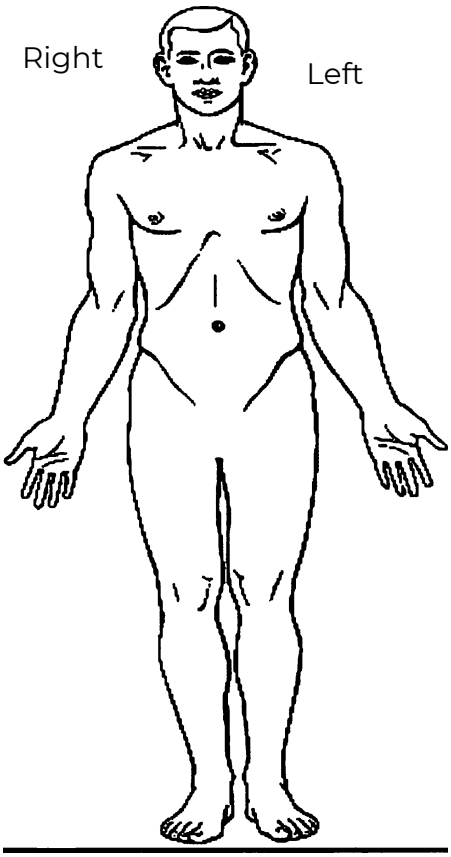
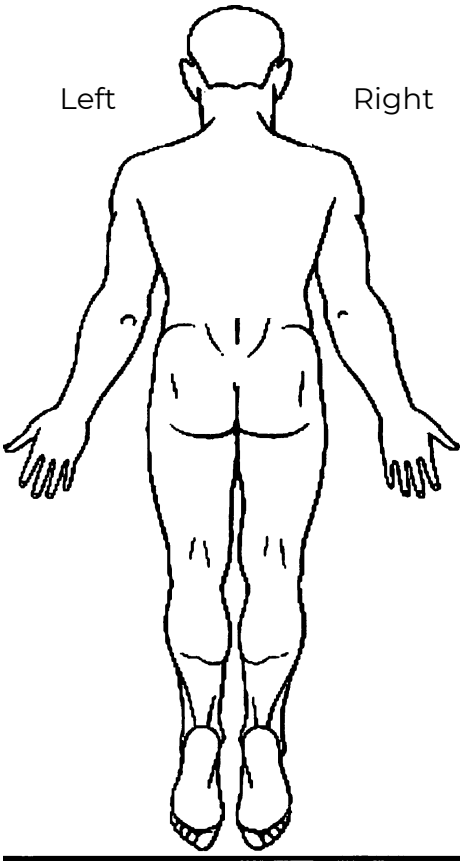
Name: _____

Date: _____

Please mark an "X" on the body part(s) where you have pain, an "0" on the body part(s) where you have numbness.





Select a number to indicate typical level of pain

Neck

0 1 2 3 4 5 6 7 8 9 10

No Pain | Mild Pain | Moderate Pain | Severe Pain | Worst Possible Pain

Back

0 1 2 3 4 5 6 7 8 9 10

No Pain | Mild Pain | Moderate Pain | Severe Pain | Worst Possible Pain

Right Arm

0 1 2 3 4 5 6 7 8 9 10

No Pain | Mild Pain | Moderate Pain | Severe Pain | Worst Possible Pain

Right Leg

0 1 2 3 4 5 6 7 8 9 10

No Pain | Mild Pain | Moderate Pain | Severe Pain | Worst Possible Pain

Left Arm

0 1 2 3 4 5 6 7 8 9 10

No Pain | Mild Pain | Moderate Pain | Severe Pain | Worst Possible Pain

Left Leg

0 1 2 3 4 5 6 7 8 9 10

No Pain | Mild Pain | Moderate Pain | Severe Pain | Worst Possible Pain

AVALA PHYSICIAN NETWORK

Patient Name:_____ Date of Birth:_____

Covered Benefits: As a courtesy, we will verify and file your claim with your insurance carrier, however we cannot guarantee payment. You are responsible for payment of any deductible, co-payment/coinsurance, and any non-covered services as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. If your insurance company denies any part of your claim or if you or your physician elect to continue therapy past your allowed/approved visits, payment will be expected from you. Verification is only an explanation of benefits based upon information that we received from your insurance carrier. It is not a guarantee of payment. Please contact your insurance carrier directly to confirm your individual benefits for Physical Therapy services.

Co-Payments: Co-payments and Co-insurance amounts must be paid at each visit according to your insurance contract. Please plan accordingly. We accept cash, checks and credit cards (Visa or Master Card).

Attendance Policy: Your physician allocates a specific amount of time for your appointment to meet the needs of your rehabilitation program. We understand that there are times when you must miss an appointment, but request that you give us 24-hour notice. Please schedule a make-up appointment as soon as possible to help meet your rehabilitation goals. So that we may provide attentive care to each of our patients, please be aware that if you arrive more than 15 minutes later than your scheduled time, you may be asked to reschedule your appointment.

I have read the above statements. It is my understanding that I am financially responsible to **AVALA** for the services provided to me or my dependent. I authorize my insurer to pay any benefits directly to **AVALA**. I agree to pay the full amount of all charges incurred by the above-named patient that are not covered by my insurance provider.

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. When an appointment is not cancelled at least 24 hours in advance you will be charged a twenty-five-dollar ($25) fee; this will not be covered by your insurance company.

_____ _____

Patient Signature Date

_____ _____

Guarantor's Signature Date

Medical Release: I hereby authorize **AVALA** to release my medical records to physicians, insurance companies, and other social agencies as necessary. I also authorize AVALA to obtain any portion of my medical record from another institution that is deemed medically necessary during my treatment. **Initial** _____

Consent to Provide Treatment: I hereby authorize **AVALA** through its appropriate personnel to perform upon me or the above-named patient appropriate physical therapy assessment and treatment procedures relating to my diagnosis. **Initial** _____

AVALA PHYSICIAN NETWORK

Accident Questionnaire

Patient: _____ Date of Birth: _____

Were you injured in a MOTOR VEHICLE ACCIDENT? ☐ Yes ☐ No

Did your injury take place while you were working? ☐ Yes ☐ No

If NO, please sign and date the bottom of this page

If YES, please complete the following:

Insured's Name: _____ Relationship to Insured: _____

Policy #: _____ Group Number: _____

Reason for Today's Visit: _____

Date of Accident/Injury: _____

Length of pain or problem _____

Where/When/How? _____

_____ _____

Patient's Signature Date

AVALA PHYSICIAN NETWORK

PAIN MANAGEMENT AGREEMENT

The purpose of this Agreement is to prevent misunderstandings about certain medicines you will be taking for pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this Agreement.

I understand that if I **break this Agreement, my doctor will stop prescribing these pain-control medicines.**

In this case, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

I will not use any illegal controlled substances, including marijuana, cocaine, etc.

I will not share, sell or trade my medication with anyone.

I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctor.

I will safeguard my pain medicine from loss or theft. Lost or stolen medicines will not be replaced.

I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.

I agree to use the below pharmacy for filling prescriptions for all pain medications.

Pharmacy Name: _____

Address: _____

Phone Number: _____

I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the state's Board of Pharmacy, in the investigation of any possible misuse, sale or any other diversion of my pain medication. I authorize my doctor to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I agree that I will submit to a blood or urine test if required by my doctor to determine my compliance with the program of pain control medicine.

I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

I will bring all unused pain medication to every office visit.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this documentation has been given to me.

This agreement is entered into on this_____day of _____

Patient Signature: _____

Physician Signature: _____

Witnessed by: _____

AVALA PHYSICIAN NETWORK

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Required for all Authorization for Release of PHI or Right of Access

Patient Name:	Birth Date:
Patients Address:	Social Security # (optional)
PHI Recipient Name:	Fax Number:
PHI Sender Name:	Fax Number:

This Authorization will expire on the following: (Fill in the Date or Event, but not both)

Dates: _____ Event:_____

Please check which of the following you would like to be requested

☐ ALL PHI in record	☐ Physician Orders	☐ Demographics
☐ History and Physical	☐ Laboratory	☐ Rehabilitation Services
☐ Consult Report	☐ Imaging/Radiology	☐ Special Test/Therapy
☐ Operative Report	☐ Nursing Notes	☐ Itemized Bill/Claims
☐ Progress Note	☐ Medication Record	☐ Other

I acknowledge and herby consent to such, that the release information may contain alcohol, drug abuse, psychiatric. HIV testing, HIV results or AIDS information._____(Initial) If not applicable, check here .
I understand that:

1. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings).
2. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
3. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal regulations and may be re-disclosed.
4. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
5. I will receive a copy of this form after I sign it.

Section C: Signatures
I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/Patient Representative:	Date:
Print Name of Patient's Representative:	Relationship to Patient:

AVALA PHYSICIAN NETWORK

DESIGNATION OF INDIVIDUAL INVOLVED IN MY CARE

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you have the right to authorize the release of your protected health information, including medical and billing records, to an individual(s) you designate. Please complete this form in its entirety designating the individual(s) with whom you would like AVALA to share your information.

Patient Name: _____ **Date of Birth:** _____

Designation of Individual(s) Involved in My Care:

At my request, I hereby identify the following individual(s):

_____

_____.

(Collectively, the "Designated Individual") as an individual(s) involved in my care and I hereby authorize AVALA to release any and all protected health information about me, including billing and medical records, to the Designated Individual. This authorization permits the disclosure of paper records, electronic records and verbal communications. Additionally, to the extent my medical or billing records contain information related to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing, HIV/AIDS, and/or other sensitive information, I hereby agree to its release

Termination/Revocation of Designation: Unless terminated sooner in writing by me, this authorization will terminate three (3) years after my last date of treatment by AVALA. I understand that I may revoke this authorization and cancel this designation by sending a written Revocation of Designation Form to AVALA. I understand and acknowledge that the revocation or cancellation of this designation shall not apply to information that has already been released prior to the revocation/cancellation date.

Re-Disclosure: I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

No Obligation to Sign: I understand that I do not have to sign this authorization and treatment of me will not be denied if I do not sign this form. I hereby release and discharge AVALA, its employees, agents and owners of any liability and will hold them harmless or complying with this authorization

Signature: _____ Date: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ hereby acknowledge that I have received a copy of the Notice of Privacy Practices of **AVALA. Initial:** _____

AVALA PHYSICIAN NETWORK

BONE HEALTH ORDERING PROTOCOL

Date: _____ **Referring Physician:** _____

Name: _____ **Date of Birth:** _____

> Have you had a Bone Density Scan in the last two years? ☐ Yes ☐ No

> Are you considering an arthroplasty joint surgery or spinal fusion? ☐ Yes ☐ No

> Do you currently have a Primary Care Provider? ☐ Yes ☐ No

> If so, who is your Primary Care Provider and their contact number?

Please check the applicable boxes below:

☐ Male ≥ 70 Years

☐ Female ≥ 65 Years

☐ History of Bone Fracture After Age ≥ 50 Years

History of the following (check all that apply):

☐ Greater Than 5 Alcoholic Beverages Per Week

☐ Chronic Steroid Usage

☐ Diabetes

☐ Family History of Osteoporosis

☐ History of Cancer W/ Chemotherapy or Radiation Treatment

☐ Inflammatory Bowel Disease or Malabsorption Disorder

☐ Low Calcium or Vitamin D

☐ Multiple Myeloma

☐ Postmenopausal

☐ Rheumatoid or Inflammatory Disease

☐ Smoking

☐ Thyroid or Parathyroid Disease