SHARKKS
Therapy

PATIENT INFORMATION				
First Name:	Last Name:		Middle:	
Best Phone Number to be Contacted:	Cell Phone Number:	Home Phone Number:	Birth date:	Sex:
Street Address:				
City:	State:	ZIP Code:		
Email Address:				

EMERGENCY CONTACT		
Name:	Relation:	Cell:

PHYSICIAN INFORMATION		
Doctor Name:	Practice Name:	
Address:	City:	ZIP Code:

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)		
Insurance Company Name:		
I.D. Number:	Group Number:	
Policyholder:	DOB:	Relation:

SECONDARY INSURANCE INFORMATION		
Insurance Company Name:		
ID Number:	Group Number:	
Policyholder:	DOB:	Relation:

I certify that SHARKKS Therapy has made available to me a copy of Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bill or in the performance of SHARKKS Therapy's health care operations. The Notice of Privacy Practices also describes my rights and SHARKKS Therapy's duties with respect to my protected health information. SHARKKS Therapy reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

___ I understand and agree to pay a $50.00 fee for any No-Show appointment or for any appointment cancelled with less than a 24-hour notice.

___ I understand and acknowledge that I am financially responsible for all charges, whether paid by insurance or not. I also acknowledge direct assignment of my rights and benefits under my insurance policy to SHARKKS Therapy, LLC.

I hereby authorize payment directly to SHARKKS Therapy, LLC of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not covered by insurance for services rendered on my behalf or my dependents. I authorize the above providers to release any information required to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient Signature (Parent/Guardian if a minor): _____Date: _____

SHARKKS
Therapy

PATIENT INFORMATION AND CONSENT FORM

CONSENT FOR CARE AND TREATMENT: I hereby agree and give my consent to SHARKKS Therapy to furnish appropriate rehabilitative care and treatment, as considered necessary and in the best interest to attend to the patient's needs. I understand that the benefits and risks to all interventions will be explained and that the patient holds the final judgement in such matters.

MEMBER DIRECT PAYMENT NOTIFICATION: Arizona state constitution permits you to pay a healthcare provider for health care services directly. If you have any active health insurance coverage, please review the provider's policies regarding payment before you make any arrangements to pay directly. By signing below, I agree to have my physical, occupational and speech therapy claims submitted to the medical insurance carrier that I have supplied.

AUTHORIZATION TO PAY: I hereby authorize insurance payment directly to SHARKKS Therapy Billing Department, 20783 N. 83rd Ave, Suite 103, Peoria 85382 for my medical services rendered. I understand that I am financially responsible for the charges not covered by my insurance. In the event of default, I promise to pay collection costs and reasonable fees as may be required to obtain collection of this account.

ATTENDANCE AGREEMENT: Due to the nature of occupational, physical and speech therapy, your progress and full recovery are dependent on both our experienced therapists, and your active participation and commitment to your appointment. If you call to cancel your appointment on the same day as your appointment or if you do not show, a $35.00 cancellation fee will be assessed.

WORKERS COMPENSATION PATIENTS: We are required to inform your Workers' Compensation Adjuster and/or Rehabilitation Manager of all missed or cancelled appointments. It is also required that all missed visits be rescheduled.

PHOTOGRAPHY/VIDEOGRAPHY AGREEMENT: I understand that in order to protect the confidentiality of our patients, there can be no filming, going "live" via social media or taking pictures of my treatment, or that of other patients, without prior authorization from the Practice Manager.

AUTHORIZATION TO COMMUNICATE ELECTRONICALLY: I understand that authorized personnel (including my physical, occupational and/or speech therapist) from SHARKKS Therapy may communicate with me regarding scheduling appointments, the treatment provided, home exercise programs, and education/informative content as it relates to my condition. I understand that my protected health information (PHI) will not be communicated electronically. I understand that I have the opportunity to opt-out of future communication via text or email.

By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document.

Printed Name: _____

Patient/Guardian Signature: _____ Date: _____

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HIPAA AUTHORIZATION FOR DISCLOSURE OF PHI

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. We are required to provide this notice to you by the Health Insurance Portability and Accountability Act (HIPAA).

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician who referred you to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used as needed to obtain payment for your therapy services.

Healthcare Operations: We may use or disclose, as needed, your health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office.

In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA), I grant permission to SHARKKS Therapy to disclose protected health information (as defined in HIPAA) to the following person or persons:

Name: _____Relationship: _____ Cell: _____

Name: _____Relationship: _____ Cell: _____

Name: _____Relationship: _____ Cell: _____

Patient Name (Print): _____ Date: _____

Patient Signature (Parent/Guardian if a minor): _____

SHARKKS
Therapy

PHOTOGRAPHIC CONSENT AND RELEASE FORM

I hereby consent that SHARKKS Therapy had to take or use photographs of me (and/or my property) and to use these in all media worldwide including online, now, or hereafter known, and for any purposes whatsoever.

I hereby release to SHARKKS Therapy all rights to exhibit this work in print and electronic form publicly or privately and to market copies. I waive any rights, claims or interest I may have to control the use of my identity or likeness in the photographs and agree that any uses described herein may be made without compensation or additional consideration of me.

I represent that I am at least 18 years of age, I have read and understand the foregoing statement, and am competent to execute this agreement.

Printed Name: _____ Date: _____

Patient/Guardian Signature: _____

SHARKKS
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APPOINTMENT CANCELLATION POLICY

We understand that unforeseen circumstances may arise, and you may need to cancel an appointment. If that happens, we respectfully ask that all scheduled appointments be cancelled at least 24 hours in advance.

Our therapists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses the chance to be seen. Although we have always had a cancellation policy, circumstances have caused us to enforce our policy of charging for No-Show appointments, and those appointments not cancelled within 24 hours. As of January 1st, 2025, there will be a fee of $50.00 assesses if we do not receive a call to cancel an appointment in our office. Home visits will have a cancellation fee of $50.00.

Thank you for your understanding and cooperation as we enforce this policy. We value you and want to see you succeed.

~ *The staff of SHARKKS Therapy*

***I have read and acknowledged that if I do not call 24 hours before my appointment or am a No-Show, I will have to pay an additional $50.00/$50.00 before my next treatment.**

Patient Name (Print): _____ Date: _____

Patient/Guardian Signature: _____

SHARKKS Therapy

Adult Patient Intake

Name: _____ Primary Diagnosis: _____

Medical History

☐ High blood pressure (Hypertension)
☐ Low blood pressure
☐ Heart attack (Myocardial infarction)
☐ Heart disease
☐ Congestive heart failure
☐ Irregular heartbeat (Arrhythmia)
☐ Pacemaker / Defibrillator
☐ Coronary artery disease (CAD)
☐ Peripheral vascular disease
☐ Blood clots / DVT
☐ Stroke / TIA

☐ Traumatic brain injury
☐ Concussion
☐ Parkinson's disease
☐ Multiple sclerosis
☐ ALS / Motor neuron disease
☐ Seizure disorder
☐ Neuropathy
☐ Migraines / chronic headaches
☐ Balance disorder / vertigo
☐ Memory loss / dementia

☐ Arthritis (Osteoarthritis / Rheumatoid)
☐ Osteoporosis / osteopenia
☐ Chronic back pain
☐ Herniated disc
☐ Spinal stenosis
☐ Scoliosis
☐ Fibromyalgia
☐ Tendonitis
☐ Rotator cuff injury
☐ Fractures
☐ Joint replacement
☐ Muscle weakness
☐ Asthma
☐ COPD
☐ Chronic bronchitis
☐ Shortness of breath
☐ Sleep apnea
☐ Oxygen use
☐ Smoker (Previous/current)
☐ Thyroid disorder
☐ Diabetes
☐ Obesity
☐ Hormonal disorder
☐ High cholesterol

Pain Assessment

Pain Location: _____
Pain Location: _____
Pain Location: _____

Pain Level (0-10): _____
Pain Level (0-10): _____
Pain Level (0-10): _____

☐ Sharp
☐ Sharp
☐ Sharp

☐ Dull
☐ Dull
☐ Dull

☐ Aching
☐ Aching
☐ Aching

☐ Burning
☐ Burning
☐ Burning

☐ Tingling
☐ Tingling
☐ Tingling

☐ Numbness
☐ Numbness
☐ Numbness

Pain Worse With: _____ Pain Worse With: _____ Pain Worse With: _____

_____ _____ _____

Pain Improves With: _____ Pain Improves With: _____ Pain Improves With:_____

_____ _____ _____

Surgical/ Treatment History

Surgery/Treatment	Reason	When
_____	_____	_____
_____	_____	_____

Any other services you are currently/ previously received (PT/OT & SLP, Etc.):

_____

_____

Medication List

Medication Name	How Much/ Dosage	Type (Please circle)
_____	_____	Ointment Pill Drop Patch Injection Inhaler
_____	_____	Ointment Pill Drop Patch Injection Inhaler
_____	_____	Ointment Pill Drop Patch Injection Inhaler

Allergies (Latex, Cold, Heat or Meds): _____

Medical / Behavioral Conditions: _____

Reason for Referral / Current Concerns: _____

Therapy Goals

Goals for Therapy: _____

Activities you want to return to: _____

Work/Hobbies

Occupation: _____ Work Status: ☐ Full Time ☐ Part Time ☐ Unemployed/ Retired

Leisure Activities/ Hobbies: _____

_____

ADL Assistance Level

Activity	100% On Your Own	Someone Helps 25%	Someone Helps 50%	Someone Helps 75%	Someone Helps 100%
Dressing	☐	☐	☐	☐	☐
Bathing	☐	☐	☐	☐	☐
Toileting	☐	☐	☐	☐	☐
Grooming	☐	☐	☐	☐	☐
Feeding	☐	☐	☐	☐	☐
Mobility	☐	☐	☐	☐	☐

Living Environment

☐ Lives Alone ☐ Lives with Spouse ☐ Lives with Family
☐ Assisted Living ☐ Skilled Nursing ☐ Stairs
☐ Single Level ☐ Grab Bars ☐ Walker / Cane
☐ Wheelchair

Fall Risk History

☐ Falls in the last 12 months
☐ Fear of falling
☐ Difficulty with balance
☐ Uses assistive device (cane, walker, wheelchair)

Patient Acknowledgment and Signature

I certify that the information provided in this medical history form is accurate and complete to the best of my knowledge. I understand that providing incorrect or incomplete information may affect my care.

I authorize healthcare providers to use this information for diagnosis, treatment, and administrative purposes as necessary.

Patient (Guardian/Representative) Name (Print): _____ **Date:** _____

Patient (Guardian/Representative) Signature: _____

Relationship to Patient: _____ **Date:** _____

SHARKKS
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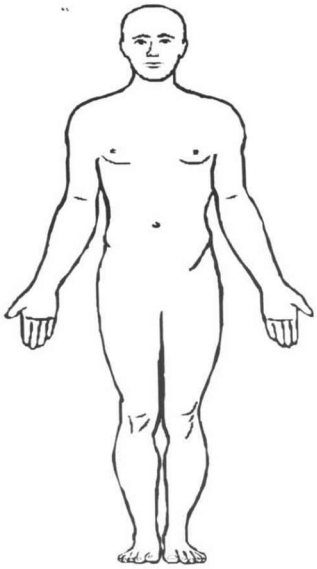
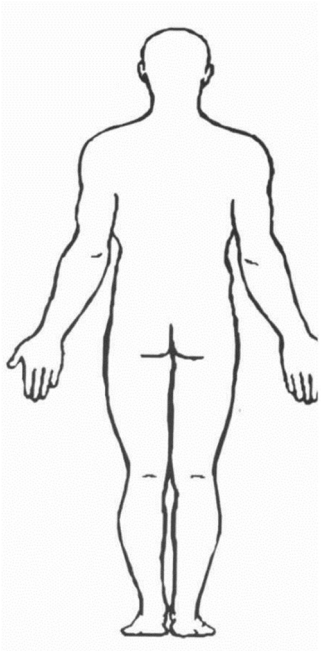
Please use the diagram provided to mark where your symptoms are currently.





Symbols to use:

(@) Aching **(X) Burning**

(/) Stabbing **(=) Numbness**

(o) Pins and Needles **(#) Radiates**

My symptoms are made better by: _____

_____

_____

_____

_____

My symptoms are made worse by: _____

_____

_____

_____

_____

My symptoms are: (Please circle one)

-Constant **-Intermittent** **-Chronic**

Are your work or activities of daily living limited?

-Yes **-No** **-Partially**