1050 E. Ray Rd. Ste 4-A
Chandler, AZ 85225
Ph: 480-659-2000
Fax: 480-659-2123

LifeQuest
PHYSICAL MEDICINE AND REHAB

Patient Application for Treatment

Name_____ **Nickname** _____

DOB: _____ Age _____ **Gender (check one) ❑ Male ❑ Female ❑ Unspecified**

Address_____ **City/State** _____ **Zip Code** _____

Cell Phone_____ **Home Phone** _____

Email _____

How did you hear about us? ❑Patient Referral_____ ❑ Dr. Referral _____
❑ Law Firm_____ ❑ Google ❑ Webpage ❑ Yelp ❑ Event ❑ Radio
❑ Other _____

What is the best way to contact you? (Check one) ❑ Email ❑ Cell Phone ❑ Home Phone

I would prefer appointment reminder notifications by (check one) ❑ Text ❑ Email

Marital Status (check one) ❑ Single ❑ Married ❑ Other **Do you have Children? ❑ Yes ❑ No How Many** _____

Employment Status (check one) ❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑Self Employed

Occupation_____**Employer**_____**Phone**_____

Emergency Contact _____**Phone#**_____

Do you have insurance? ❑ Yes❑ No Insurance Name_____**ID #** _____**SSN**_____

Race (check one)

❑ White	❑ Black/African American	❑ Hispanic	❑ American Indian	❑ Samoan
❑ Asian	❑ Asian Indian	❑ Chinese	❑ Philipino	❑ Other
❑ Japanese	❑ Korean	❑ Vietnamese	❑ Native Hawaiian	❑ Choose not to specify

Primary Care Physician _____**Address** _____**Phone** _____

Would you like our physicians to communicate your condition & course of care with your PCP? ❑ Yes ❑ No

When was your last Physical examination? _____

When did you last have blood work? ❑ Within a Year ❑ Over a Year ❑ Not Sure

Have you ever been referred to a specialist? ❑ Yes ❑ No If yes, describe: _____

Have you ever had chiropractic care? ❑ Yes ❑ No

Has anyone in your family received chiropractic care? ❑ Yes ❑ No

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

Alcohol: ❑ **None ❑ Yes: How many drinks/day** _____**frequency/week** _____**What kind**_____

1050 E. Ray Rd. Ste 4-A
Chandler, AZ 85225
Ph: 480-659-2000
Fax: 480-659-2123

LifeQuest
PHYSICAL MEDICINE AND REHAB

What is YOUR goal for treatment?

_____

1. **Chief Complaint** _____ **When did it start?** _____ **Gradual/Sudden**

Circle the current pain level of your complaint?
1 2 3 4 5 6 7 8 9 10
Mild **Severe**

Circle the percentage of the day you experience the complaint?
10 20 30 40 50 60 70 80 90 100
How would you rate the pain at its worse? (1-10) _____

2. **Chief Complaint** _____ **When did it start?** _____ **Gradual/Sudden**

Circle the current pain level of your complaint?
1 2 3 4 5 6 7 8 9 10
Mild **Severe**

Circle the percentage of the day you experience the complaint?
10 20 30 40 50 60 70 80 90 100
How would you rate the pain at its worse? (1-10) _____

3. **Chief Complaint** _____ **When did it start?** _____ **Gradual/Sudden**

Circle the current pain level of your complaint?
1 2 3 4 5 6 7 8 9 10
Mild **Severe**

Circle the percentage of the day you experience the complaint?
10 20 30 40 50 60 70 80 90 100
How would you rate the pain at its worse? (1-10) _____

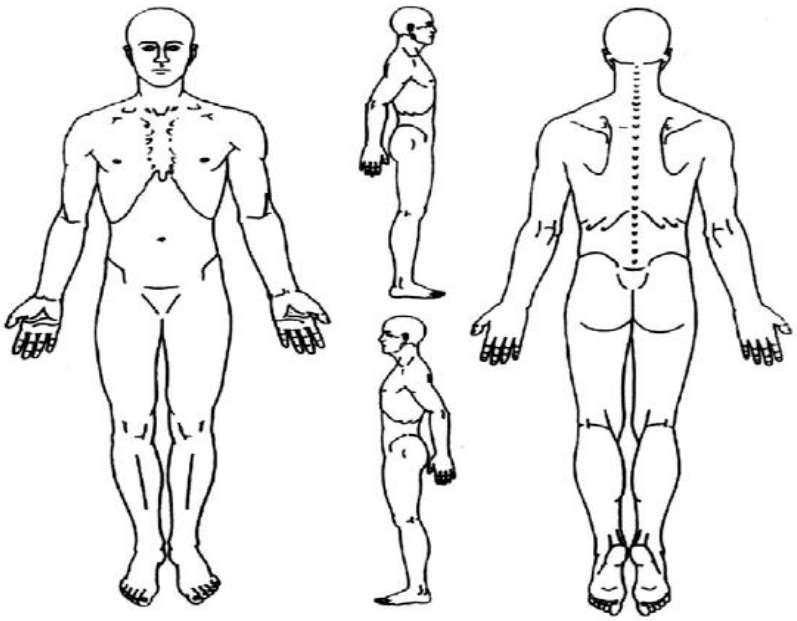
What job activities are you unable to do? _____

When do you feel it most? □ AM □ PM **When present, how long does the complaint last?** _____ **Mins** _____ **Hrs**

What makes it feel better? _____ **What makes it feel worse?** _____

Using the letters below, please show <u>where</u> you are experiencing all of your current complaints:

A. Ache
B. Burning
C. Cramping
D. Dull Pain
F. Stiffness
N. Numbness
R. Throbbing
S. Soreness
T. Tingling
X: Sharp Pain
SP: Shooting Pain
RP: Radiating Pain



Do you currently have pain and/or difficulty performing any of the following activities?

Walking	**Y**	**N**
Standing	**Y**	**N**
Running	**Y**	**N**
Sleeping	**Y**	**N**
Driving	**Y**	**N**
Personal Grooming	**Y**	**N**
Sitting	**Y**	**N**
Kneeling	**Y**	**N**
Exercising	**Y**	**N**
Bending	**Y**	**N**
Lifting Objects	**Y**	**N**
Lifting Children	**Y**	**N**
Housework	**Y**	**N**

1. **Have you ever had tests for your present condition? ❑ MRI ❑ X-ray ❑ CT ❑ Other**
2. **Do you have a pacemaker? ❑ Yes ❑ No**
3. **Have you ever lost work due to your condition(s)? ❑ Yes ❑ No If Yes, dates?** _____

In the event we can help, please indicate to us what your level of commitment would be to correcting your problem (s)?

(Low) 0 1 2 3 4 5 6 7 8 9 10 (High)

1050 E. Ray Rd. Ste 4-A
Chandler, AZ 85225
Ph: 480-659-2000
Fax: 480-659-2123

LifeQuest
PHYSICAL MEDICINE AND REHAB

Current medications, including dosage if known: **If there are no current medications, check here: ❑**

1) _____ **5)** _____

2) _____ **6)** _____

3) _____ **7)** _____

List any known allergies you have had to any medications, foods or environment:

1) _____ **3)** _____

2) _____ **4)** _____

Past Medical History:

❑Head Aches/Migraines
❑Stroke
❑Seizures
❑Pneumonia
❑Diabetes (Type 1 or Type 2)
❑Thyroid Disease (Low or High)
❑Glaucoma
❑Macular Degeneration
❑Hearing Loss
❑High Blood Pressure
❑Blood Clots
❑Pulm Emboli (lung clots)
❑DVT (leg clots)
❑Heart Burn, Reflux
❑Stomach Ulcers
❑Heart Disease
❑Coronary Disease
❑MI/heart attacks
❑Congestive Heart Failure
❑Atrial Fibrillation
❑Angina (Chest pain)
❑Valve Disorder
❑High Cholesterol
❑Gastrointestinal Bleeding
❑Hepatitis (A, B, C)
❑HIV / AIDS
❑Chronic Wounds
❑Cancer (type)
❑Urinary Tract Infections
❑Incontinence
❑Kidney Stones
❑COPD (Emphysema, Bronchitis)
❑Asthma
❑Depression
❑Anxiety
❑Fibromyalgia
❑Chronic Fatigue Syndrome
❑Arthritis
❑Gout
❑Osteoporosis

Past Surgical History (indicate date if known)

❑ None
❑ Cataracts/LASIK_____
❑ Tonsillectomy_____
❑ Thyroidectomy_____
❑ Coronary Bypass_____
❑ Cardiac Stents_____
❑ Pacemaker_____
❑ Heart Valve_____
❑ Gall Bladder_____
❑ Appendectomy_____
❑ Hysterectomy _____
❑ Bowel/Stomach Resection_____
❑ Bariatric surgery_____
❑ Hernia_____
❑ Spinal Surgery_____
❑ Tubal Ligation_____
❑ Bladder surgery_____
❑ Prostate surgery/resection_____
❑ C-Section_____
❑ Orthopedic/joints_____
❑ Other _____

1050 E. Ray Rd. Ste 4-A
Chandler, AZ 85225
Ph: 480-659-2000
Fax: 480-659-2123

LifeQuest
PHYSICAL MEDICINE AND REHAB

FAMILY HISTORY: Please check any condition that YOU or YOUR FAMILY have or have had in the past. Please state (P) for Patient or (F) for family****

❑ Alcoholism	**(P or F)**	❑ High Blood Pressure	**(P or F)**	❑ Stroke	**(P or F)**
❑ Anemia	**(P or F)**	❑ Kidney Disease	**(P or F)**	❑ Suicide Attempt	**(P or F)**
❑ Asthma	**(P or F)**	❑ Liver Disease	**(P or F)**	❑ Thyroid Disease	**(P or F)**
❑ Cancer/Tumor	**(P or F)**	❑ Hepatitis	**(P or F)**	❑ Tuberculosis, TB	**(P or F)**
❑ Diabetes	**(P or F)**	❑ Lung Disease	**(P or F)**	❑ Ulcers	**(P or F)**
❑ Drug Abuse	**(P or F)**	❑ Mental Illness	**(P or F)**	❑ Venereal Disease	**(P or F)**
❑ Depression	**(P or F)**	❑ Osteoarthritis	**(P or F)**	❑ High Cholesterol	**(P or F)**
❑ Epilepsy/Seizures	**(P or F)**	❑ Osteoporosis	**(P or F)**	❑ HIV or Other Immune Disease	**(P or F)**
❑ Glaucoma	**(P or F)**	❑ Phlebitis	**(P or F)**	❑ Other _____	
❑ Heart Disease	**(P or F)**	❑ Rheumatic Arthritis	**(P or F)**		

Please check any conditions that you have now or have had in the past

GENERAL
- ❑ Weight Loss / Gain
- ❑ Fatigue
- ❑ Fever

EYES
- ❑ Glasses/Contacts
- ❑ Eye Pain
- ❑ Double Vision
- ☐ Cataracts

EAR, NOSE, THROAT
- ❑ Difficulty Hearing
- ❑ Ringing in Ears
- ❑ Vertigo/Dizziness
- ❑ Sinus Trouble
- ❑ Nasal Stiffness
- ❑ Frequent Sore Throat

CARDIOVASCULAR
- ❑ Heart Murmur
- ❑ Chest Pains
- ❑ Palpitations
- ❑ Fainting Spells
- ❑ Shortness of Breath
- ❑ Difficulty Lying Flat
- ❑ Swelling Ankles

ENDOCRINE
- ❑ Loss of Hair
- ❑ Heat/Cold Intolerance

RESPIRATORY
- ❑ Coughing
- ❑ Coughing Blood
- ❑ Wheezing

GASTROINTESTINAL
- ❑ Heartburn/Reflux
- ❑ Nausea/Vomiting
- ❑ Constipation
- ❑ Change in BMs
- ❑ Diarrhea
- ❑ Jaundice
- ❑ Abdominal Pain
- ❑ Black/Bloody BM

GENITOURINARY
- ❑ Painful Urination
- ❑ Frequent Urination
- ❑ Blood in Urine
- ❑ Erectile Dysfunction
- ❑ Abnormal Discharge
- ❑ Bladder Leakage

ALLERGIES
- ❑Food
- ❑ Environmental
- ❑ Medication
- ❑ Hives/Eczema
- ❑ Hay fever

PYSCHIATRIC
- ❑ Anxiety/Depression
- ❑ Mood Swings

HEMATOLOGY
- ❑ Easy Bruising
- ❑ Bleeding Gums
- ❑ Enlarged Glands

MUSCULOSKELETAL
- ❑ Joint Pain/Swelling
- ❑ Stiffness
- ❑ Numbness in toes/fingers
- ❑ Weakness in hands, feet, arm or legs
- ❑ Muscle Pain
- ❑ Loss of muscle Strength
- ❑ Back Pain

SKIN
- ❑ Rash/Sores
- ❑ Itching/Burning
- ❑ Lesions

NEUROLOGICAL
- ❑ Headaches
- ❑ Tremors
- ❑ Memory Loss

FEMALES ONLY

Date of Last Mammogram _____
Normal Abnormal
Date of Last Pap_____
Normal Abnormal
Date of Last Period_____
Are you pregnant? Y / N

Patient Signature: _____**/Print Name:**_____

Date: _____ **Dr. Initials** _____

Staff Use Only: **Height:** ____inches **Weight:** _____ pounds **BP:** _____ /_____

1050 E. Ray Rd. Ste 4-A
Chandler, AZ 85225
Ph: 480-659-2000
Fax: 480-659-2123

LifeQuest
PHYSICAL MEDICINE AND REHAB

Welcome to LifeQuest

At LifeQuest Physical Medicine and Rehab, we strive to meet our patient's needs. Our patient's health comes first at all times. We are always pleased to discuss our professional fees with you at anytime. Your clear understanding of our financial policy is important to our professional relationship. Please ask any questions you may have regarding our fees or your responsibility in complying with our any questions you may have regarding our fees or your responsibility in complying with our financial policy and/ or procedures.

Limited Release of Medical Information: In the event that any insurance company, or other 3rd party, obligated to make payment to me or to LifeQuest Physical Medicine and Rehab for the charges made for the services, refuses to make such payment upon demand, I herby assign, transfer, and convey to LifeQuest Physical Medicine and Rehab any and all cause of action that might exist in my favor against such company or person. I authorize LifeQuest Physical Medicine and Rehab to prosecute said action in my name or their name to collect fees due for care rendered and legal expenses, and to resolve said claims as they see fit.

Collection/ Attorney Fees: I agree to pay all costs of collection agency, if necessary, to obtain payment in the event legal action should become necessary to collect an unpaid balance due for medical services. I agree to pay reasonable attorney fees or other such costs as the court determines proper.

Uninsured Patients: No patient will carry a personal cash balance. Payment is due when services are rendered. We gladly accept Visa, MC, American Express, Discover, check or cash. We also offer EFT services for payment plan agreements.

Insurance Patients: Our clinic provides billing for individual or group insurance policies, personal injury claims, authorized workers' compensation, and Medicare. All recommended professional services that are covered/ limited by the **out- of- network** portion of your health insurance and are rendered to you will be charged to your health insurance on your behalf. I understand that my health insurance is a contract between me, the insurance carrier, and the provider. I understand that I am ultimately responsible for any services rendered to me that are not covered by my insurance company. I agree to pay my portion of fees at the time treatment is rendered. If your current health insurance policy is terminated for any reason and there are dates of service that were rendered prior to termination, you will also be responsible for any remaining balance.

If you receive checks in the mail for services rendered by our office, it is your responsibility to bring the checks in immediately with any supporting documents. If you do not provide the checks and/or supporting documents, you will be responsible for the entire balance due for that date of service.

1. **General Consent to Treatments:** I herby request and consent to the performance of the indicated procedures (or on the patient below, for whom I am legally responsible) by the Doctors of Chiropractic, Medical Doctors, Nurse Practitioners and/or Doctors of Physical Therapy and assistants who now or in the future work at this office or any other LifeQuest Physical Medicine and Rehab office. Including but not limited to any and all necessary ancillary diagnostic services I have agreed to and acknowledge to have done. I have had an opportunity to discuss with the Doctors practicing in this clinic and/or with the other office or clinic personnel the nature and purpose of the procedures indicated for me. I understand that the results are not guaranteed. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic and physical therapy there are some risks to treatments, including but not limited to fractures, disk injuries, strokes, dislocations and sprains. I do not expect the Doctor to be able to anticipate and explain all risks and possible complications, and I wish to rely upon the Doctor to exercise judgment during the course of procedure which the Doctor feels at the time, based upon the facts then known to him or her, is in my best interest.
2. **Informed Consent for Injection Therapies:** By signing, I authorize LifeQuest Physical Medicine and Rehab and staff to administer injections that my healthcare provider considers reasonable and necessary. I understand that all injection treatments are commonly, but not always, accompanied by risks, including, but not limited to, bruising, temporary increase in pain, inflammation, and temporary numbness. I also understand that more serious reaction may occur, including, but not limited to: infections, allergic reactions, prolonged numbness, weakness, paralysis, spinal headache from Dural puncture, lung puncture or death as a result of or related to injection treatment. I understand that there are various types of injections that are commonplace in the practice of pain management including but not limited to trigger point, intramuscular, intra-articular (joint), tendon, ligament, nerve blocks or other forms of injections.
3. **Right to refuse treatment:** I acknowledge that I have the opportunity to discuss the nature and purpose, alternative methods or treatments, the risks, potential complications and associated risks associated with any treatment or procedure recommended by a healthcare provider of my choice. I also understand that I retain the right to refuse any particular examination, diagnostic tests, procedure, treatment, therapy or medication recommended or considered medically necessary by my healthcare provider. I also understand that due to the nature of the practice of medicine, there is no guarantee as to the results of my evaluation and treatment to my satisfaction, and I understand I may ask any additional questions I may have at any time.

I intend for this consent to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment for at this office, or any other LifeQuest Physical Medicine and Rehab clinics.

1050 E. Ray Rd. Ste 4-A
Chandler, AZ 85225
Ph: 480-659-2000
Fax: 480-659-2123

LifeQuest
PHYSICAL MEDICINE AND REHAB

Patient Bill of Rights and Responsibilities

To ensure the finest care possible, as a Patient receiving medical care or Durable Medical Equipment (DME) you should understand your role, rights and responsibilities involved in your own plan of care.

Patient Rights

- To select those who provide you with Medical, Chiropractic and DME services
- To receive the appropriate or prescribed services in a professional manner without discrimination relative to your age, sex, race, religion, ethnic origin, sexual preference or physical or mental handicap
- To be treated with friendliness, courtesy and respect by each and every individual representing our Clinic, who provided treatment or services for you and be free from neglect or abuse, be it physical or mental
- To assist in the development and preparation of your plan of care that is designed to satisfy, as best as possible, your current needs, including management of pain
- To be provided with adequate information from which you can give your informed consent for commencement of services, the continuation of services, the transfer of services to another health care provider, or the termination of services
- To express concerns, grievances, or recommend modifications to your medical care or DME services, without fear of discrimination or reprisal
- To request and receive complete and up- to- date information relative to your condition, treatment, alternative treatments, risk of treatment plans
- To receive treatment and services within the scope of your plan of care, promptly and professionally, while being fully informed as to our Clinic's policies, procedures and charges
- To request and receive data regarding treatment, services, or costs thereof, privately and with confidentially
- To be given information as it relates to the uses and disclosures of your plan of care
- To have your plan of care remain private and confidential, except as required and permitted by law

Patient Responsibilities

- To provide accurate and complete information regarding your past and present medical history
- To agree to a schedule of services and report any cancellation of scheduled appointments and/or treatments
- To participate in the development and updating of a plan of care
- To communicate whether you clearly comprehend the course of treatment and plan of care
- To comply with the plan of care and clinical instructions
- To accept responsibility for your actions, if refusing treatment or not complying with, the prescribed treatment and services
- To respect the rights of Clinic's personnel
- To notify your Physician with any potential side effects and/ or complications

By signing below, you are indicating that you have read and understand and agree to the above conditions of this office:

_____ _____
Patient/Legal Guardian Signature **Date**

_____ _____
Staff Signature **Date**

Note: This is a confidential record and will be kept in this office. Information contained here will not be released to anyone without authorization to do so.

1050 E. Ray Rd. Ste 4-A
Chandler, AZ 85225
Ph: 480-659-2000
Fax: 480-659-2123

LifeQuest
PHYSICAL MEDICINE AND REHAB

Health Care Information Authorization

At times our office may need to contact you with appointment information about treatment or other health related information. By signing below, you are giving LifeQuest Physical Medicine and Rehab authorization to contact you by the following:

(Please draw a single line through any methods you REFUSE and initial)

- ✓ **I may be contacted by** home, work, or cell phone.
- ✓ **Messages may be left** on my home, work, or cell voicemail OR to any individuals answering my phone at home or work.
- ✓ **Also I may be contact by postal mail or e-mail** to send personalized cards (birthday/holiday/special events), office newsletter, special office announcements or appointment reminders. With my permission, my name and or photograph may be used for office events, bulletin board, newsletters or patient testimonials

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of ***LifeQuest Phsyical Medicine and Rehab*** The written notice must contain the following information:

- Your name, social security number and date of birth
- A clear statement of your intent to revoke this AUTHORIZATION
- The date of your request
- Your signature

The revocation is not effective until it is received by the Privacy Official.
This AUTHORIZATION is requested by ***LifeQuest Physical Medicine and Rehab*** for its own use/disclosure of protected health information. (Minimum necessary standards apply.)You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, ***LifeQuest Physical Medicine and Rehab*** will not refuse to provide treatment. You have the right to inspect or copy the protected health information to be used/ disclosed.

** A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU IF REQUESTED **

PERSONAL REPRESENTATIVES (family members, attorneys, etc. I hereby authorize LifeQuest Physical Medicine and Rehab and its employees permission to discuss, send and/or receive medical information to/with the following individuals:

We like to co-manage your case with your Primary Care Physician; do you authorize us to send notes or records to them? Y/N

If Yes, please provide us the following information: Primary Care Doctor _____Office Phone # _____

My signature below indicates that I have read and agree to the above authorization and I acknowledge that I have read a copy of *LifeQuest Physical Medicine and Rehab's* Notice of Privacy Practices.

_____ _____

Patient Name Printed **Personal Representative Name Printed**

_____ _____

Patient Signature **Signature of Personal Representative**

_____ _____

Date **Personal Representative Authority to act for Patient**

1050 E. Ray Rd. Ste 4-A
Chandler, AZ 85225
Ph: 480-659-2000
Fax: 480-659-2123

LifeQuest
PHYSICAL MEDICINE AND REHAB

Office Policy, Procedures& Disclosures

Medical/Chiropractic Department:
(Please initial next to each item below)

_____I understand that there is a $25 charge for missed appointments without a 24 hour advance notice or a NO CALL NO SHOW for any appointment with the Medical Doctor, Physician Assistant, Nurse Practitioner or Chiropractic.

_____ I understand that the patient is ultimately responsible for full payment for their treatment and care. Your insurance Policy is a contract between you and your insurance. As a courtesy, we will file your claim. However, the patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated.

Patients are responsible for the payments of copays, co-insurance, deductibles, and all other procedures, treatments or services not covered by their insurance plan. Patients are responsible for contacting their insurance carrier for explanation of any services not covered. Payment is due at the time of service, and for your convenience, we accept cash, check, and most major credit cards at our office.

Patients may incur, and are responsible for the payment of additional charges at the discretion of LifeQuest Physical Medicine and Rehab. These charges may include but are not limited to (subject to change at any time)

_____I have been offered copies and reviewed LifeQuest Physical Medicine and Rehab's complaint procedures, emergency preparedness, home safety and equipment warranty procedures.

_____**Assignment of Benefits (AOB)-** I request that payment of authorized Medicare benefits be made to me or on my behalf to LifeQuest Physical Medicine and Rehab for durable medical equipment and supplies ordered by my physician. I authorize any holder of medical information about me to release to the Center for Medicare Medicaid Services and its agency any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If 'other insurance' is indicated in item 9 of the CMS-1500 claim form, or elsewhere on the approved claim form or electronically submitted claims, my signature authorizes releasing the information to the insurer or agency listed. In Medicare assigned cases, the supplier agrees to accept the charge of determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered items. Coinsurance and the deductible are based upon the charge determination to the Medicare carrier.

Massage Department:
(Please initial next to each item below)

_____I understand that there is a 24 hour cancellation policy for ALL massages, in place at LifeQuest Physical Medicine and Rehab.

_____ I understand that I lose the right to any free massages if I do not cancel 24 hours before the scheduled massage.

_____ I understand that I lose one massage from my package if I do not cancel 24 hours before the scheduled massage.

_____ I understand that I will be charged the $25.00 if I do not cancel 24 hours before the scheduled massage.

_____ I understand that I, not the insurance company, personal injury case, or workers compensation case, will be charged the value of the massage if I do not cancel 24 hours before the scheduled massage.

Miscellaneous:
(Please initial next to each item below)

_____ I understand that there is a $40 charge for forms completion by our Providers, including but not limited to disability and FMLA forms

MEDICARE PATIENTS ONLY:

_____The products and/or services provided to you by LifeQuest Physical Medicine and Rehab are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained at http://www.ecfr.gov. Upon request, we will furnish you a written copy of the standards.

1050 E. Ray Rd. Ste 4-A
Chandler, AZ 85225
Ph: 480-659-2000
Fax: 480-659-2123

LifeQuest
PHYSICAL MEDICINE AND REHAB

Disclosure:
A physician must notify a patient that the physician has a direct financial interest in a separate diagnostic or treatment agency to which the physician is referring the patient and/or in the nonroutine goods or services being prescribed by the physician, and whether these are available elsewhere on a competitive basis. A.R.S. §32-1401(27)(ff). (I/We) support this law, because it helps patients make reasoned financial decisions concerning their medical care. In compliance with the requirements of this law, you are being advised (I/We) have a direct financial interest in the diagnostic or treatment agency or in the non-routine goods or services named below. Further, as indicated below, goods or services (I/We) have prescribed are available elsewhere on a competitive basis.

DIAGNOSTIC OR TREATMENT AGENCY OR NON-ROUTINE GOODS AND SERVICES:
Valley Pain Intervention Center_____
Laboratories: Insight Labs
ARE THESE SERVICES AVAILABLE ELSEWHERE ON A COMPETITIVE BASIS?
_X_ Yes ___ No
If yes, which ones:
Local Pain Centers and Laboratories: AZ Pain Treatment Centers, Lab Corp, Sonora Quest Labs

****

I have read, understand, and agree to the provisions of this Patient Financial Responsibility and Disclosure Form:
Please sign/date below:

Printed Patient Name:_____ **Date**: _____

Signature of Patient: _____ **Witness**:_____

1050 E. Ray Rd. Ste 4-A
Chandler, AZ 85225
Ph: 480-659-2000
Fax: 480-659-2123

LifeQuest
PHYSICAL MEDICINE AND REHAB

PERSONAL INJURY QUESTIONNAIRE

Name _____ Birth Date ____/_____/_____ Phone # _____

Address _____ City _____State _____ Zip _____

Details of the Accident (Please circle appropriate responses)

1. Date of Accident _____ Time of Day _____ AM / PM
2. Road Conditions: Dry Wet Icy Gravel Road Pavement Other _____
3. Were You: Driver Passenger Front Seat Back Seat
4. What direction were you headed? North South East West
   On (Name of Street) _____
5. Were you struck from: Front Rear Left Side Right Side
6. Were you aware of the impending collision? Yes No
7. Did you lose consciousness (black out)? Yes No
   If yes, for approximately how long were you unconscious? _____
8. Were you wearing a seatbelt at the time? Yes No
   What type of belt? Lap Belt Shoulder Belt Shoulder & Lap Belt
9. Describe the position of your head rest or seat back relative to the position of your ears at impact: Above Below # inches _____
10. List the year, make and model of the vehicle you were in:
    Year _____ Make _____ Model _____
11. Was the vehicle you were in at the time of impact: Stopped Moving
    If stopped, was driver's foot on the brake? Yes No
    If moving, estimate approximate speed of the vehicle _____
12. In your own words, please describe the accident:

13. Were the police notified of the accident? Yes No
14. Please describe what happened to you following the accident (i.e. transported to the hospital by ambulance, taken to hospital by friend, etc.):

15. Please describe bleeding cuts or bruises received as a result of your accident:

16. Please describe if any of your body parts struck any part of the vehicle. For example, head hit windshield, chest hit steering wheel, etc.:

17. Was your head pointed straight ahead at the time of the accident? Yes No
    If no, which direction was it turned and by how much?

1050 E. Ray Rd. Ste 4-A
Chandler, AZ 85225
Ph: 480-659-2000
Fax: 480-659-2123

LifeQuest
PHYSICAL MEDICINE AND REHAB

18. Was your torso pointed straight ahead at the time of the accident? Yes No
    If no, which direction was it turned and by how much?
19. Which of the following vehicle parts broke during the accident?
    Windshield Rt/Lt Window Front/Back Seat Steering Wheel Other _____
20. What was the cost of damage to the vehicle you were in? _____

****

The following questions pertain to the other vehicle involved in the accident:

1. What was the year, make and model of the other vehicle?
   Year _____ Make _____ Model _____
2. Was the other vehicle moving at the time of the collision? Yes No
   If yes, what was the vehicle's approximate speed? _____
3. If the other vehicle was moving at the time of the accident, was it:
   Slowing Down Gaining Speed Traveling at a steady speed

****

Health History Questions

1. What are your complaints or symptoms (since the accident)?

2. Did you have any physical complaints BEFORE THE ACCIDENT? Yes No
   If yes, please describe in detail:

3. Have you received treatment for this injury since the accident?
   If yes, please list the doctor's name and address and describe the type of treatment received:

4. If you have been in previous auto accidents or have received treatment for any other significant injuries other than described above, please list the type of accident or injury and the approximate date below:

To the best of my knowledge, the information provided above is true and correct.

_____ _____

Patient's Signature Date

1050 E. Ray Rd. Ste 4-A
Chandler, AZ 85225
Ph: 480-659-2000
Fax: 480-659-2123

LifeQuest
PHYSICAL MEDICINE AND REHAB

Personal Injury Insurance Information

Patient Name _____

Date of Accident _____

Please provide as much information as possible so your case can be set up to your financial advantage. In the state of Arizona insurance law reads that you have the right to bill any insurance policy under which you have coverage. In the case of more than one insurance coverage and overpayment may occur. We only need to be paid once, so all overpayments will be reimbursed to you at the time you are released from care of settlement of your case. _____ (Patient Initials)

****

Medical Payment Coverage

On your automobile insurance, or the policy for the car in which you were driving/passenger, there may be coverage called "Med Pay". This coverage is for any injuries that may have occurred to someone in the automobile, whether the accident was or wasn't your fault. If you were not at fault, using this portion of the policy cannot raise your premium or affect your record in any way. This is why you pay for "Med-Pay" on your insurance policy. _____ (Patient Initials)

Claimant's Name _____Policy Holder _____

Name of Insurance Company _____

Phone # _____ Policy # _____

Adjuster Name _____Claim # _____

****

Third Party (Liability) Coverage

This is the insurance information for the person who was in the "other car". The information can be found on the accident report.

Driver's Name _____ Policy Holder _____

Name of Insurance Company _____

Phone # _____ Policy # _____

Adjuster Name _____Claim # _____

****

Attorney Information

Firm Name _____

Name of Attorney _____

Phone # _____

Legal Assistant Name _____

1050 E. Ray Rd. Ste 4-A
Chandler, AZ 85225
Ph: 480-659-2000
Fax: 480-659-2123

LifeQuest
PHYSICAL MEDICINE AND REHAB

PATIENT FINANCIAL AGREEMENT
(Equitable Lien/ Assignment Contract and Indemnification Agreement)

Please read the following very carefully as it concerns your financial responsibility to the Health Care or Service Provider from whom you are about to receive services.

I, _____, [***the undersigned patient***] herby agree to establish an irrevocable lien/ assignment of benefits or claim in favor of **LifeQuest Physical Medicine and Rehab** by this contract and pursuant to any state statues that apply in the state where I reside. I give my permission for **LifeQuest Physical Medicine and Rehab** and/ or its agent, to file, record, and serve notice of this agreement (lien/assignment) upon myself and all other parties who may be liable to me for damages arising from this accident which occurred on or about _____[***date***], and any subsequent claims arising from this accident for which I am about to receive health care services. I understand that by doing so I have entered into a contract with **LifeQuest Physical Medicine and Rehab**. This agreement authorizes direct payment to **LifeQuest Physical Medicine and Rehab** from any and all proceeds from any insurance policy, settlement, compromise, judgement, verdict, or damages to which I may be entitled and paid in connection with the settlement of claims or litigation arising from this accident, in such sums necessary to fully compensate **LifeQuest Physical Medicine and Rehab.** The lien/ assignment created by this Equitable Lien Contract and Indemnification Agreement shall have priority from the time and date on which said documents are actually filed, or recorded or served on the liable parties, over any subsequent liens or assignments of my interests in claims arising from this accident.

On behalf of **LifeQuest Physical Medicine and Rehab,** I authorize to furnish my attorney and their agents and/or any applicable insurance company with a full report of the examination, diagnoses, prognoses and treatment and billing in regards to the accident resulting in my injury(ies) from the motor vehicle accident occurring on or about _____. This shall include disclosure of HIV results, substance abuse issues and any other information required by law.

I authorize and direct my attorney and or applicable insurance company to directly pay such sums that may be due and owing for professional services provided to me by reason of my accident, and to withhold such sums from any settlement, judgement, collateral source or verdict, as may be required to adequately protect **LifeQuest Physical Medicine and Rehab.** I further direct my attorney and/or applicable insurance company to pay **IN FULL** amounts owed to **LifeQuest Physical Medicine and Rehab** arising out of treatment of my injuries from said accident.

I irrevocably agree to list **LifeQuest Physical Medicine and Rehab** on any settlement draft(s)/ check(s). I also agree that this lien and all the rights granted to **LifeQuest Physical Medicine and Rehab** will continue in full force and be binding upon me and counsel if I change attorneys in the future. Should I change attorneys, I will notify **LifeQuest Physical Medicine and Rehab** promptly of the same. Should I obtain
new counsel, or not provide current whereabouts within a reasonable period of time, then **Life Quest Physical Medicine and Rehab** may deal directly with any applicable insurance company, so as to satisfy said lien obligation.

I also provide, by signing below, durable power of attorney on behalf of **LifeQuest Physical Medicine and Rehab** to be able to endorse and draft/ check on my behalf, so that any outstanding amount due and owing **LifeQuest Physical Medicine and Rehab** can be satisfied without any additional signatures from me.

I agree and acknowledge that this lien can and may be sold and reassigned and recognize that the purchaser of the lien will be entitled to all the rights, as expressed herein.

I understand that I am directly and fully responsible to **Life Quest Physical Medicine and Rehab** for all amounts due and owing and that this lien is being provided solely as additional protection to **Life Quest Physical Medicine and Rehab.** I provide this lien in consideration of **LifeQuest Physical Medicine and Rehab** waiting on payment. I further recognize that payment **to LifeQuest Physical Medicine** is not continent upon settlement, judgment, or verdict that I may or may not eventually obtain as reimbursement of said fee.

I finally agree that I shall not submit, without express permission from **LifeQuest Physical Medicine and Rehab** the medical bills arising out of such lien for payment to any private health plan or state or federal government sponsored health plan, including but not limited to, Medicare and Medicaid. I also further agree that I will see LifeQuest Physical Medicine and Rehab medical providers on a lien basis, and allow billing to my private health insurance if I have any and only if my health insurance allows balanced billing. Should my health insurance not allow balance billing I agree to forego submission to my health insurance and allow my attorney to pay medical provider all expenses out of my settlement proceeds. If **LifeQuest Physical Medicine and Rehab** elects to bill an indemnification plan neither my attorney nor I will assert a claim for pro rata of attorney fees for collection of settlement funds or make a claim for reduction under ***Samaritan vs. LaBombard*.**

1050 E. Ray Rd. Ste 4-A
Chandler, AZ 85225
Ph: 480-659-2000
Fax: 480-659-2123

LifeQuest
PHYSICAL MEDICINE AND REHAB

I further understand that as part of the process of recording a lien/ assignment, I will receive certified mail with a copy of the lien/ assignment enclosed and that this company copy is for my own records and does not require any response on my part.

_____ _____

Patient's Signature Date

The undersigned, being attorney of record, does hereby acknowledge receipt of the above lien, does further acknowledge good and valuable consideration to **LifeQuest Physical Medicine and Rehab** acceptance of this lien, and does agree to honor the same to protect **LifeQuest Physical Medicine and Rehab** adequately.

_____ _____

Attorney's Signature Date