Trident Lake Health Inc.
Trident Lake Physical Therapy (TLPT)
4140 E Bethena St, Gilbert, AZ 85295
Phone (480) 256-9633 | Fax (480) 631-0526 | info@tridentlakehealth.com | www.tridentlakehealth.com

PATIENT INTAKE PACKET — PHYSICAL THERAPY

Mobile (we come to you) · Telehealth · In-Clinic coming soon

Please return this completed packet with a copy of your photo ID, the front and back of all insurance cards, and your physician's referral/prescription (if you have one).

PATIENT INFORMATION

Patient Name First _____ Middle _____ Last _____

Date of Birth _____ Sex ◯ Male ◯ Female ◯ Other Occupation _____

Address _____

City _____ State _____ ZIP _____

Primary Phone _____ Alternate Phone _____ Email _____

May we leave a message? ◯ Yes ◯ No May we email you? ◯ Yes ◯ No May we text you? ◯ Yes ◯ No

Preferred Language _____ Interpreter needed? ◯ Yes ◯ No

Parent/Guardian (if patient is under 18) _____ Phone _____

Emergency Contact _____ Relationship _____ Phone _____

HOW WOULD YOU LIKE TO RECEIVE CARE?

Check your preferred visit type(s). We will confirm availability for your area and insurance.

☐ Mobile therapy — at home, work, or community ☐ Telehealth (video) ☐ No preference

☐ In-clinic — COMING SOON (check if you would like us to contact you when our clinic opens)

Mobile visit address, if different from home _____

Preferred days ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat **Times** ☐ Morning ☐ Afternoon ☐ Evening

How did you hear about us? _____

REASON FOR THERAPY

Program ☐ General / orthopedic PT ☐ Chronic pain / complex care ☐ Lymphedema ☐ Pelvic health

☐ TMJ / craniofacial ☐ Vestibular / balance ☐ Oncology rehabilitation ☐ Other: _____

Main problem / body area _____

When did it start? _____ How? ◯ Gradually ◯ Suddenly ◯ Injury / accident ◯ After surgery

Pain (0–10): Now _____ At best _____ At worst _____

Pain type ☐ Aching ☐ Sharp ☐ Burning ☐ Throbbing ☐ Numbness ☐ Tingling ☐ Other: _____

What makes it worse? _____ What makes it better? _____

Had treatment for this problem before (PT, chiropractic, injections, surgery)? ◯ Yes ◯ No

If yes, what and when:

Daily activities that are hard for you now (work, sports, sleep, stairs, lifting, etc.):

Your goals for therapy:

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REFERRAL & INSURANCE

Do you have a physician referral/prescription? ◯ Yes ◯ No Referring Provider _____

Referring Provider Phone _____ Fax _____ Next MD visit _____

Primary Care Physician _____ Phone _____

Payment ☐ Insurance ☐ Self-pay ☐ Workers' comp ☐ Auto / personal injury ☐ AHCCCS plan

If workers' comp/auto: Claim # _____ Date of injury _____ Adjuster/attorney & phone _____

Primary Insurance

Insurance Company _____

Member/Policy # _____ Group # _____

Policy Holder _____ Holder DOB _____

Relationship to Patient _____ Holder SSN (last 4) _____ Employer _____

Secondary Insurance

Insurance Company _____

Member/Policy # _____ Group # _____

Policy Holder _____ Holder DOB _____

Relationship to Patient _____ Holder SSN (last 4) _____ Employer _____

MEDICAL HISTORY

Check any condition you have now or have had:

☐ High blood pressure	☐ Heart disease	☐ Pacemaker / implanted device	☐ Blood clots (DVT/PE)
☐ Diabetes	☐ Cancer (current or past)	☐ Lymphedema / swelling	☐ Osteoporosis
☐ Arthritis	☐ Stroke	☐ Seizures	☐ Dizziness / vertigo
☐ Falls in the last 12 months	☐ Headaches / migraines	☐ Jaw pain / clicking	☐ Bladder or bowel leakage
☐ Pelvic pain	☐ Currently pregnant	☐ Recent infection / fever	☐ Unexplained weight loss
☐ Numbness / tingling	☐ Lung / breathing problems	☐ Kidney disease	☐ Other: _____

Current medications (name, dose):

Allergies (medications, latex, adhesive tape, lotions)? ◯ Yes ◯ No List _____

Past surgeries / hospitalizations (type and date):

Have imaging (X-ray, MRI, CT) for this problem? ◯ Yes ◯ No Type / date _____

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CONSENTS & AUTHORIZATIONS

CONSENT TO EVALUATE & TREAT

I consent to evaluation and treatment by Trident Lake Physical Therapy (TLPT) licensed physical therapists and assistants. Treatment may include exercise, manual (hands-on) therapy, modalities, education, and a home program. Results are not guaranteed. I may ask questions, decline any part of treatment, or stop care at any time.

Patient/Guardian Signature _____ **Date** _____

PELVIC HEALTH CONSENT (PELVIC HEALTH PATIENTS ONLY)

Pelvic health evaluation may include external assessment and, only if clinically indicated and fully explained first, an internal (vaginal or rectal) examination or treatment. I may decline or stop any part at any time and may request a chaperone.

☐ I consent to external pelvic assessment/treatment ☐ I consent to internal assessment/treatment if indicated ☐ N/A

Patient/Guardian Signature _____ **Date** _____

MOBILE THERAPY ACKNOWLEDGEMENT (MOBILE VISITS ONLY)

- Provide a safe, clear space for treatment and a place to park; secure pets before the therapist arrives.
- A parent/guardian or responsible adult (18+) must be present for patients under 18.
- The therapist may end or reschedule a visit if the setting is unsafe.

Patient/Guardian Signature _____ **Date** _____

TELEHEALTH INFORMED CONSENT (COMPLETE IF TELEHEALTH IS SELECTED)

Telehealth sessions with Trident Lake Physical Therapy (TLPT) use a secure, HIPAA-compliant video platform. I understand that: telehealth has the same confidentiality protections as in-person care; technical problems may interrupt a session, and the therapist may reschedule or switch to phone; the therapist may decide a visit must be in person; I can withdraw consent and request in-person services at any time; a responsible adult must be present for patients under 18; and in an emergency during a session, the therapist will call 911 to the location I provide.

Patient location during telehealth (address) _____

Has a device with camera and reliable internet? ◯ Yes ◯ No

Patient/Guardian Signature _____ **Date** _____

FINANCIAL RESPONSIBILITY & ASSIGNMENT OF BENEFITS

I request that insurance benefits for services by Trident Lake Physical Therapy (TLPT) be paid directly to Trident Lake Health Inc. I am responsible for deductibles, co-pays, co-insurance, non-covered services, and self-pay charges. Workers' comp or auto patients remain responsible if a claim is denied.

Patient/Guardian Signature _____ **Date** _____

RELEASE OF MEDICAL INFORMATION

I authorize Trident Lake Physical Therapy (TLPT) to exchange relevant information, including diagnoses and treatment records, with my referring provider, physicians, other health care providers, and my insurance company, workers' compensation carrier, or other payers, as needed for my care and for payment.

Patient/Guardian Signature _____ **Date** _____

ATTENDANCE & CANCELLATION POLICY

Cancellations	Call (480) 256-9633 at least 24 hours ahead. When appropriate, a cancelled mobile visit may be offered as telehealth.
Late arrival	Visits start on time. If you are more than 15 minutes late (or not available for a mobile/telehealth visit), the visit may be shortened or rescheduled.
No-shows	No contact before a missed visit is a no-show. Two no-shows, or frequent late cancellations, may result in removal from the schedule or discharge.

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By signing, I acknowledge that I have read, understand, and agree to follow the TLPT Attendance & Cancellation Policy.

Patient/Guardian Signature _____ **Date** _____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name _____ DOB _____

I voluntarily authorize Trident Lake Physical Therapy (TLPT) to disclose or exchange the patient's health information, in writing or verbally, with the person(s) or organization(s) listed below, in addition to the parties named in the Release of Information in this packet.

#	Name / Organization	Relationship	Phone	Fax or Email
1				
2				
3				

Information to release: ☐ All records ☐ Evaluations / plans of care ☐ Progress notes ☐ Billing ☐ Other: _____

This authorization expires on _____ (if blank, one year from the date signed)

Rediscloure: once information is disclosed to the recipient above, it may no longer be protected by federal privacy law and could be redisclosed. Right to refuse or revoke: I may refuse to sign or revoke this authorization at any time by written notice; this will not affect the patient's treatment, payment, or eligibility for services. Revocation takes effect when received, except for actions already taken in reliance on this authorization.

Printed Name _____ Relationship to Patient _____

Patient/Guardian Signature _____ **Date** _____

NOTICE OF PRIVACY PRACTICES — ACKNOWLEDGEMENT

Trident Lake Physical Therapy (TLPT) protects the patient's health information as required by HIPAA. A full Notice of Privacy Practices is available on request at any time and at www.tridentlakehealth.com. In summary, we may use and disclose health information:

- Treatment — to coordinate care with your physicians and other providers.
- Payment — to bill and collect payment from you, your insurance, or other payers.
- Health care operations — quality review, training, licensing, and accreditation activities.
- As required by law — including reports of suspected abuse, neglect, or exploitation and to avert a serious threat to health or safety.
- Appointment reminders — by phone, voicemail, text, or email, based on the preferences you gave above.
- We will not use your information for marketing without your written authorization.

You have the right to request a copy of your records, request corrections, request limits on certain disclosures, request confidential communications, and receive an accounting of disclosures. Questions or privacy complaints: (480) 256-9633 or info@tridentlakehealth.com.

By signing below, I acknowledge that I received or was offered the Notice of Privacy Practices.

Patient/Guardian Signature _____ **Date** _____

PRE-SERVICE ORIENTATION ACKNOWLEDGEMENT

By signing below, I confirm that the information in this packet is complete and accurate to the best of my knowledge, that it serves as my pre-service orientation, and that it will be reviewed by Trident Lake Physical Therapy (TLPT) provider(s) before services begin. I will tell Trident Lake Physical Therapy (TLPT) about any changes.

Patient/Guardian Signature _____ **Date** _____

OFFICE USE ONLY

Received by _____ Date _____ Chart / MR # _____

☐ Photo ID copied ☐ Insurance cards (front/back) copied ☐ Eligibility verified ☐ Entered in EMR

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