Leslie Putt, MPT, CZB
OPTIMAL YOU | 8114 E. Cactus Road, #240 | Scottsdale, AZ 85260 | 480-812-5262

Leslie M Putt PT, LLC is committed to excellence in serving the health needs of the community. We are dedicated to giving each client a personal service that they can rely on & trust. To help us meet your needs please fill out this form completely. If you have any questions or need help, please ask, we will be happy to assist you.

Patient Information

Name: Last _____ *First* _____ *MI* ____ *Date* _____/_____/_____

Current address _____

City _____ *State* _____ *Zip* _____

Phone #: H _____ *W* _____ *C* _____

Male *Female* *Date of Birth:* _____/_____/_____

Employer _____ *Occupation* _____

Employer address _____

City _____ *State* _____ *Zip* _____

Family Doctor _____

Who can I thank for this referral? _____

Cancellation / No Show Policy:
If you need to cancel your appointment, please call us ASAP (24 hours notice) so we have the opportunity to offer your appointment to another patient. If less than 24 hours notice is given or you do not show up, you will be charged for the amount of time you were scheduled at a rate of $140/hour.

Initial _____

Consent for Care and Treatment:
Your physical therapist will complete an evaluation process via interview and examination. From these findings, a treatment plan will then be designed, utilizing a variety of treatment techniques. I, the undersigned, do hereby agree and give consent for Leslie M Putt PT LLC to provide physical therapy care and treatment identified as proper and necessary in addressing my physical condition.

Initial _____

I agree that the information above is accurate. I understand the terms of this form and realize that I am financially responsible for charges incurred from cancellations or no shows.

Patient Name: _____ Date: _____/_____/_____

Patient Signature: _____

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Payment Policy

In striving to provide each individual with personalized service, Leslie M Putt PT LLC accepts payments via cash, check, Visa or MasterCard. We ask for full payment to be rendered at the time of service.

Treatment Price List

Treatment Session	Price
15 Minute "Quick Balance"	$40.00
30 Minutes	$75.00
1 Hour	$140.00
5 Hours (Prepaid)	$600.00 (save $100)
10 Hours (Prepaid)	$1,150.00 (save $250)
15 Hours (Prepaid)	$1,650.00 (save $450)

Executive Wellness Program

Treatment Session (Performed at Your Location)	Price
1 Hour	$220.00
5 Hours (Prepaid)	$1,000.00 (save $100)
10 Hours (Prepaid)	$1,950.00 (save $250)
15 Hours (Prepaid)	$2,850.00 (save $450)

Referral Rewards Program

We APPRECIATE Your Referrals!

As a heartfelt "Thank You" for telling your friends, coworkers and family members about the unique personalized services offered at Leslie M Putt PT LLC, we would like to offer YOU the following incentive program:

- You will receive a 20% discount for each new client you refer to Leslie M Putt PT LLC (a $30 value!)
- You will receive 2 free hours for every 5 new clients you refer to Leslie M Putt PT LLC (a $300 value!)

Gift Certificates Available Upon Request

Appointments are typically 2 hours. Some appointments may be longer so we can maximize as much change in one visit as possible. When requested, Leslie M Putt PT LLC will provide the information you will need to submit to your insurance for possible reimbursement.

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Patient Signature: _____

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Medical History

Do you:

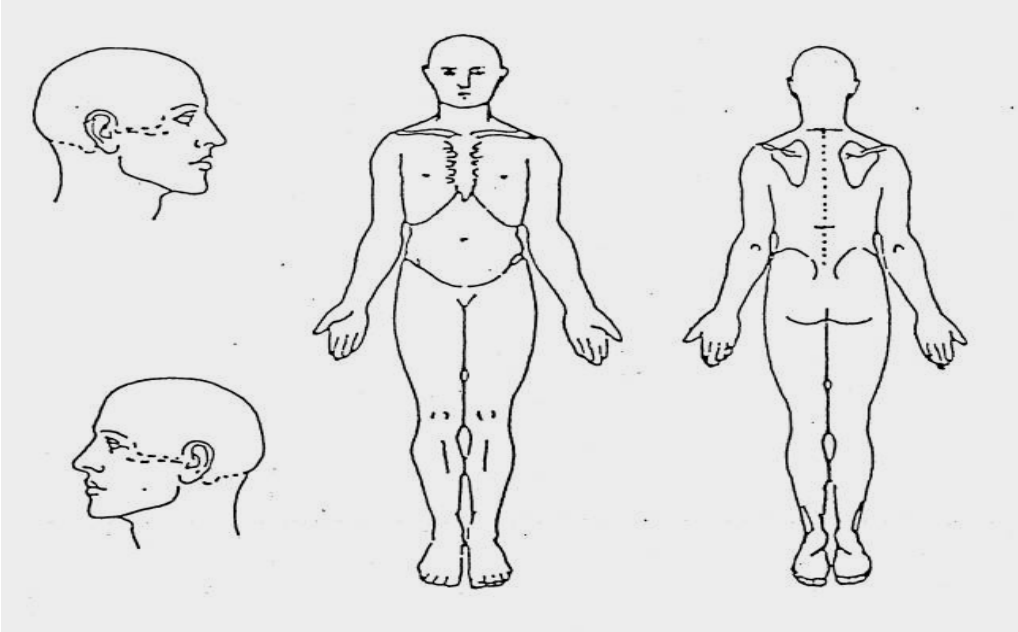
Smoke	Yes	No	Years smoked: _____
			Packs per day: _____
Use artificial sweeteners:	Yes	No	
Drink diet soft drinks:	Yes	No	Drinks per day: _____
Usually sleep through the night:	Yes	No	
Sleep with a pillow between your knees:	Yes	No	
Take any statin drugs (cholesterol lowering):	Yes	No	

Current medications:

Allergies to: drugs, food or other items (including latex):

Current symptoms:

Please indicate on the diagram the location of your current symptoms:



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Do you exercise? Yes No

If yes, what type of exercise? _____

How often? _____

Pain Level: (0 being none and 10 being the worst)

0 1 2 3 4 5 6 7 8 9 10

Stress Level: (0 being none and 10 being the worst)

0 1 2 3 4 5 6 7 8 9 10

Please List All Operations/Surgeries:

Operation Performed (even as a child)	Year

Please check if YOU have had any of the following conditions

Insomnia	PTSD	Phobias _____
High Blood Pressure	High Cholesterol	Stroke
Mental Illness/Depression	Candida (yeast allergy)	Eating Disorder
Diabetes (type I or II)	Heart Attack/Disease	Brain Injury
Arthritis	Celiac Disease	Migraine Headaches
Thyroid Dysfunction	Asthma	Blood Clots
Cancer	Dizziness	Shortness of breath
Alcoholism	Anxiety	Heart palpitations
Substance abuse	Irritable bowel syndrome	Reflux
Fibromyalgia	Chronic fatigue syndrome	Lyme disease
Restless leg syndrome	Diarrhea	Concussion
Carbon monoxide poisoning	Difficulty swallowing	Stuttering
Multiple chemical sensitivity	Difficulty speaking	Attention deficit disorder
Attention deficit hyperactivity disorder	Empty Next Syndrome	Intrusive thoughts
Sleep Apnea	Miscarriage	Sweaty hands/feet
Night sweats	Ulcers	Hemorrhoids

Other conditions not listed: _____

Patient Name: _____ Date: _____/_____/_____

Patient Signature: _____

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Notice of Health Information Practices

This notice describes how information about patients may be used and disclosed and how patients can get access to this information. Please review it carefully.

Introduction

Leslie M Putt PT LLC is committed to treating and using personal health information about all our patients responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes patient rights as they relate to personal health information. This applies to all personal health information as defined by federal regulations.

Understanding Health Records / Information

Each time a patient visits Leslie M Putt PT LLC, a record of the visit is made. Typically, this record contains symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as the health or medical record, can possibly serve as a:

- Basis for planning care and treatment,
- Means of communication among the many health professionals who contribute to the care,
- Legal document describing the care received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.
- Most likely uses of personal health information at Leslie M Putt PT LLC.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Leslie M Putt PT LLC, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy the health record (a reasonable fee may be required),
- Request an amendment of the health record,
- Obtain a list of the disclosures of the health information,
- Request a restriction on certain uses and disclosures of your information and,
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Leslie M Putt PT LLC is required to:

- Maintain the privacy of the health information,
- Provide patients with this notice as to your legal duties and privacy practices with respect to information that we collect & maintain,
- Abide by the terms of this notice,
- Notify the patients if we are unable to agree to a requested restriction.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will provide the updated policy at the time of a future visit.

Patient Name: _____ Date: _____/_____/_____

Patient Signature: _____