Ross E. Waltz, PT, MSPT
Bridgette Lesar, PT
Angelo Sakelaris, PT

Welcome to ATS Physical Therapy.

I created this physical therapy family for one reason, and one reason only-

HELPING PEOPLE TO HELP THEMSELVES!

For over 15 years the ATS staff has worked hard to ensure a successful Physical Therapy experience - doing as much as we can to assist patients in obtaining necessary paperwork to move forward with treatment. However, it must ultimately be the responsibility of the patient to present and understand:

1) Proof of insurance coverage or workers comp claim info,
2) Referrals for physical therapy (if required),
3) Appropriate (matching) identification.

Additionally, we may enlist your help in obtaining diagnostic exams, surgical reports, etc.

Under no circumstances will hostility or disrespect toward my staff or other patients be tolerated.

We do enjoy and appreciate humor, while observing mutual respect.

Let's get started!

Ross Waltz, PT, MSPT

I have read and understand the above letter-

X_____

850 Mill St., #300 ● Reno, NV 89502 ● 775-337-8776 ● Fax 775-337-8778
5990 Silver Lake, Suite D ● Reno, NV 89506 ● 775-677-8776 ● Fax 775-677-2274

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NEW PATIENT WELCOME LETTER

Dear Patient,

We want to offer you a warm welcome to our clinic and thank you for choosing our facility. We strive to provide the utmost excellence in physical therapy care and we achieve great results with our patients.

We believe ATS Physical Therapy is about **helping** people to obtain the best outcomes possible. In order for us to **help** you and to consistently offer the same **help** to others, we must agree to practice mutual respect and courtesy.

This includes:

1. We will give to each other at least 24 hours notice for canceled appointments. **ATS Physical Therapy will charge $75.00** (code 97110) for no show/no call appointments, or late notice cancels.

2. We will do everything we can to remind you of future appointments, but naturally we can't repeatedly save a "time slot" for you if you repeatedly miss it! After 3 no-show's (without prior notice of a cancellation) we reserve the right to suggest that you use another Physical Therapist (if available) for your rehabilitation.

3. Due to limited room in the clinic, we respectfully ask that guests accompanying you to your appointment wait in the waiting room.

We can't help you if you don't show up and another patient loses the opportunity to be helped when your time slot is wasted. However, we understand that from time to time situations occur that don't allow for prior calling to cancel an appointment.

Please feel free to ask any of our employees if you have any questions regarding your insurance, treatment and eventual discharge. We are all about helping people. Help us to help you!

Patient Signature_____ Date_____

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ATS PHYSICAL THERAPY
850 Mill Street, Suite 300
Reno, Nevada 89502

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- **Treatment (including direct or indirect treatment by otherhealthcare providers involved in my treatment.**
- **Obtaining payment from third party payers (e.g. my insurance company)**
- **The day-to-day healthcare operations of your practice**

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this_____day of_____, 20____.

Print Patient Name: _____

Relationship to Patient: _____

Signature: x_____

Please list a confidential phone number that a message can be left at:

Phone number: _____

ARTHRITIS, TRAUMA, SPORTS PHYSICAL THERAPY

Date _____

Patient Name_____ **Birthdate**_____ **Age**_____ **Sex: M F**

Social Security #_____ **Marital Status: S M D W**

Mailing Address_____ **City**_____ **State**_____ **Zip** _____

Physical Address_____ **City**_____ **State**_____ **Zip** _____

Home Phone_____ **Work Phone** _____

Cell Phone_____ **Email**_____

Employer_____ **Occupation**_____

Employer Address _____

Person Financially Responsible _____

Name of Emergency Contact_____ **Phone** _____

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other ☐ Decline **Language:** ☐ English ☐ Spanish ☐ Other: _____

Ethnicity: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino ☐ Decline

Spouse Information *OR* If patient is a minor, Parents Information

Name (spouse/mother)_____ **D.O.B.**_____

Employer_____ **Social Security #**_____

Employer Address_____ **Phone #** _____

Name (father)_____ **D.O.B.**_____

Employer_____ **Social Security #**_____

Employer Address_____ **Phone #** _____

INSURANCE INFORMATION

Primary Ins. Co._____ **Policy Holder** _____

Insurance Address_____ **Phone**_____

Policy or ID #_____ **Group # or Name** _____

Secondary Ins. Co._____ **Policy Holder** _____

Insurance Address_____ **Phone**_____

Policy or ID #_____ **Group # or Name** _____

Was this injury from a motor vehicle accident? Yes No Type of injury_____ **Date**_____
Did this injury happen to you at your place of employment? Yes No Date of injury _____
Do you have an attorney for this accident? Yes No Name _____

WORKERS COMPENSATION/INDUSTRIAL INFORMATION

THIS INFORMATION MUST BE COMPLETED FOR US TO BILL WORKERS COMPENSATION

Industrial Carrier_____ **Claim #** _____

Adjuster Name_____ **Adjuster Phone #** _____

Address _____

I_____ **hereby authorize the release of any information relating to all claims for insurance benefits submitted on behalf of dependants or myself. I further authorize the release of records pertaining to dependants or myself to other physicians, attorneys, and ancillary services (including, but not limited to brace shops, therapy, and home health). I give permission to contact me at my address and/or phone number of record, including leaving a message. I understand that I am financially responsible for all services rendered by this office.**

X_____ **Signature of the Patient OR Parent's if Patient is a Minor** **Date**

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PATIENT HEALTH QUESTIONAIRE

Name:_____

Age:_____Date of Birth:_____/_____/_____

Did a doctor send you to us? Yes / No

Physician's name:

_____

Please briefly describe the injury/ history/ limitations:

_____

_____

_____

How did you injure yourself?

_____

_____

_____

What is the specific date of injury?_____/_____/_____

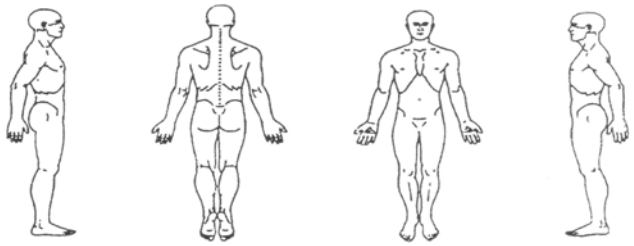
Did you have surgery associated with this complaint?

No / Yes Date: _____

Type of Surgery: _____

Where is your problem? (please mark with an "X")

Circle: Right Back Front Left



Rate your pain (please circle):

(0 = no pain, 10 = worst)

At worst: NT 0 1 2 3 4 5 6 7 8 9 10

Current: NT 0 1 2 3 4 5 6 7 8 9 10

At best: NT 0 1 2 3 4 5 6 7 8 9 10

Pain description:

_____

_____

Aggravating Factors (please check all that apply):

- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Going Up Stairs
- ☐ Down Stairs
- ☐ Sitting to Standing
- ☐ Bending
- ☐ Voiding (going to the bathroom)
- ☐ Lying down
- ☐ Coughing / Sneezing

What makes your problem worse?

_____

_____

What makes your problem better?

_____

_____

Previous treatments for this problem?
(medications, physical therapy, injections, bracing):

_____

_____

Occupation / Job?

_____

☐ Normal / Regular Duty ☐ Limited Duty

Past medical history (please check all that apply):

- ☐ No known past medical history to affect treatment
- ☐ Back Pain/ Surgery
- ☐ Neck Pain/ Surgery
- ☐ Diabetes - Type (please circle): I II
- ☐ Fibromyalgia
- ☐ Fractures
- ☐ Obesity
- ☐ Arthritis - Type (please circle): OA RA
- ☐ Parkinson's Disease
- ☐ Traumatic Brain Injury
- ☐ Other Neurological History: _____
- ☐ Epilepsy
- ☐ Other: _____

Past Diagnostic Testing/ Imaging:

- ☐ X-Ray Date:_____Where:_____
- ☐ MRI Date:_____Where:_____
- ☐ Other - Type: _____
  Date:_____Where: _____

Medications:

_____

_____

_____

Present Weight:_____Height:____feet_____inches

_____

Patient Signature **Date**

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Thank you for choosing ATS Physical Therapy

Our environment allows for open social interaction while often being in close proximity to others. To provide a comfortable experience at ATS Physical Therapy we ask that you:

Please:

Avoid profane language - be respectful of others.

Maintain regular personal hygiene.
(scented deodorants are not only ok, but are often necessary)

Clothing should be clean and appropriate for our clinical therapy setting.
(not too tight or restrictive, and clean shoes are appreciated)

With changing weather, please consider your attire and if it is appropriate for our setting. If you would like to apply deodorant, wash up, or change into clothes that are more appropriate for your physical therapy appointment, there is a rest room or changing room available.

A public restroom is located in the main hallway.

Thank You

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ARTHRITIS TRAUMA ATS PHYSICAL THERAPY SPORTS

Physical Therapy Appointment Times

Mill Street

Monday	7:00am-10:30, 1:30-4:00
Wednesday	7:00am-10:30, 1:30-4:00
Friday	7:00am-10:30
Tuesday	7:00am-10:30, 2:00-4:00
Thursday	7:00am-10:30, 2:00-4:00

*These appointment times are effective June 1st, 2018 at our clinic on Mill Street only.

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Physical Therapy Appointment Times

Stead

Monday	7:00am-10:30, 1:00-4:30
Wednesday	7:00am-10:30, 1:00-4:30
Friday	7:00am-10:30, 1:00-4:30

Tuesday	1:00-4:30
Thursday	1:00-4:30

*These appointment times are effective June 1st, 2018 at our clinic in Stead only.

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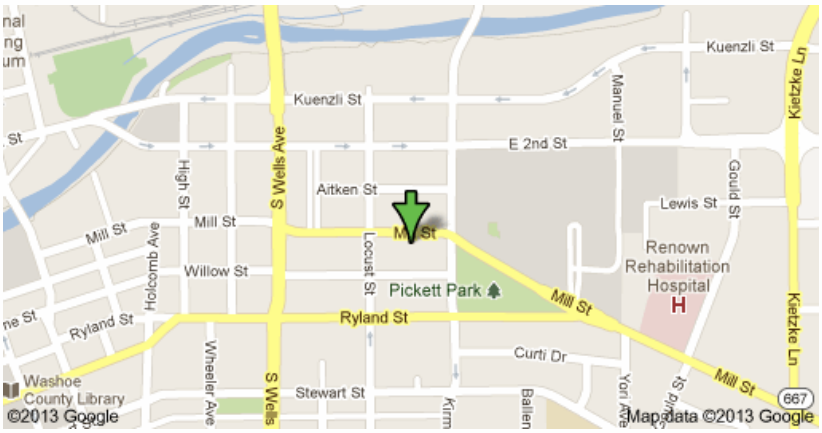
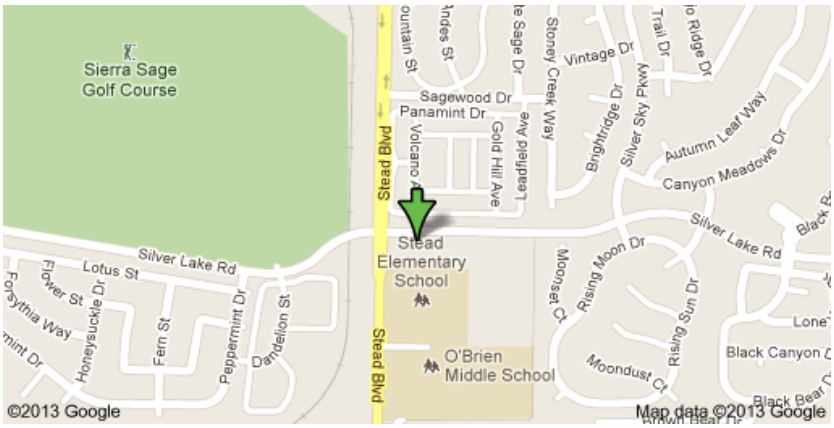


850 Mill Street, #300

From I-80
Exit Wells Ave, go south on Wells to Mill Street. Turn left on to Mill Street. We are located on the right side of Mill Street. If you reach Kirman you have gone too far.

From 395/I-580
Exit Mill Street, go west on Mill Street towards Kietzke Lane. Stay to the right at the park, go through Kirman and we are the second building located on the left side of Mill Street.



5990 Silver Lake Road, #D

From 395
Exit Stead Blvd, continue on Stead Blvd until you come to Silver Lake Road. Turn right on to Silver Lake Road and we are on the corner in the brown Medical building.

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