

Patient Registration:

Last Name: _____ First Name _____ M.I. _____ Gender: _____

Date of Birth: _____ Age: _____ Marital Status: _____ SS#(or DL#): _____

Mailing Address: _____ City: _____ State: _____

Home Phone: _____ Cell Phone: _____ Zip Code: _____

Email Address: _____ Spouse's Name (if applicable): _____

Occupation: _____ Employer: _____

Employer Address: _____ Employer Phone: _____

Primary Care Physician: _____ Referring Physician: _____

Emergency Contact Information:

Name: _____ Relationship: _____

Phone: _____

Appointment Reminders: *Please indicate preferred methods of communication.*

Yes	No	Text message
Yes	No	Email message
Yes	No	Phone call/voicemail message

Are we treating you for a work injury or motor vehicle accident *with an open claim*? YES NO

Have you recently received Home Health, Hospice or nursing home care? YES NO

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I authorize the release of any information acquired in the course of my treatment to my insurance carrier and physician, any authorized representative as appointed from time to time, and those people listed below, which authorization may be revoked in writing at any time:

Individual(s) Name:

Relationship to Patient:

Financial Responsibility:

You are responsible for any services rendered at Advanced Rehabilitation Services. As a courtesy, we will bill your insurance provided. However, any expenses not covered by insurance must be paid in full.

Co-pays: If you have an insurance plan that requires a **co-pay** for each visit, we are contractually obligated by your insurance company to collect it ***at the time of your visit.***

Deductible of \$1000 or more: If you have a **high deductible** health insurance plan with a deductible of \$1000 or more and have not met your deductible, we require an account payment *towards* the charges for each visit as follows:

Evaluation: \$175 - \$200

Regular Treatment: \$125

Self Pay Patients: (without insurance) must pay ***the full amount due*** at the end of each appointment according to our Self Pay Fee Schedule, which is available in writing upon request in compliance with the Good Faith Estimate.

PATIENT CONSENTS AND AUTHORIZATIONS

CONSENT TO RECEIVE PHYSICAL AND OCCUPATIONAL THERAPY SERVICES: I consent to the evaluation and treatment performed by my licensed physical or occupational therapist. The treatment procedures *may* include manual therapy, high velocity/low amplitude mobilization, dry needling, laser therapy, ultrasound, phonophoresis, electrical stimulation, iontophoresis, heat/cold therapy, mechanical traction, neuromuscular re-education, therapeutic exercise and therapeutic activities. My treatment plan will be based on my current presentation and the best clinical judgement of my physical or occupational therapist. Possible risks include, but are not limited to, an increase in pain, bruising, burns, bone fracture, cardiovascular complications, puncture of the lung (pneumothorax), infection and nerve injury. Serious complications or injuries resulting from physical therapy procedures are very rare and all risks will be carefully managed by my physical therapist. I understand that there are inherent risks associated with participation in physical and occupational therapy and will address any specific concerns or questions with my physical or occupational therapist during my appointment. I understand that I have the right to terminate any part of my therapy treatment at any time. I understand that no guarantees have been made regarding the outcome of the treatments provided.

AUTHORIZATION OF INSURANCE PAYMENT AND FINANCIAL RESPONSIBILITY: I authorize insurance payment directly to Advanced Rehabilitation Services, LLC for services rendered. *I understand it is my responsibility to know my insurance benefits and how physical and occupational therapy services are covered under my plan.* I accept full responsibility for payment of services not covered by my insurance. I understand that if my account is not paid in full, I am subject to be charged for any additional fees incurred by Advanced Rehabilitation Services, LLC to collect my balance, including 15% APR or 1.25% monthly on all balances not paid within 30 days of invoice date or to the maximum extent allowed by state and federal law. Advanced Rehabilitation Services, LLC reserves the right to refuse treatment to any person with outstanding balances that is not actively paying on their account.

COMMUNICATION & APPOINTMENT REMINDER CONSENT: By providing my phone number(s) and/or email address, I consent to receive communication from the clinic using these methods with regard to my care. If I choose to communicate with ARS staff using email or text message concerning my care, I understand that Advanced Rehabilitation Services, LLC has reasonable safeguards in place for my protected health information (PHI). By signing below, I consent to sending and receiving information regarding my care electronically, and accept the inherent risks of submitting information electronically. Pursuant to HIPAA guidelines, ARS is required to notify me in the event my PHI is compromised.

CANCELLATION POLICY: ARS requires 24 hours' notice in the event of a cancellation. ARS reserves the right to charge a \$40 "cancellation without notice" fee to an appointment without any notice or less than 24 hours' notice. This charge will not be billed to insurance and **MUST** be paid prior to the start of my next visit. After two no-shows, any appointments already scheduled may be automatically canceled. Management approval may be required for re-scheduling on a case-by-case basis.

NOTICE OF PRIVACY PRACTICES FOR MY PROTECTED HEALTH INFORMATION: I have been offered and/or given a copy of the HIPAA notice and have had a chance to ask questions about how my personal health information will be used. I know that I can contact the privacy official, Jennifer Reynolds, at (406) 752-7250 if I have further questions.

I have reviewed the consents and authorizations above and I agree to all of the statements.

Signature of Patient or Parent/Legal Guardian

Date

General Health Questionnaire:

Today's Date: _____

Patient's Name: _____ Date of Birth: _____ Age: _____

Referring Physician: _____ Hand Dominance: Left Right

Occupation: _____ Able to work with this problem? _____

Tobacco/Nicotine Use: Yes No If yes, type and amount: _____

Exercise: Type of Exercise: _____ How often: _____

Sleep: Hours of sleep per night? _____ Sleep interrupted by your reason for coming to physical therapy? _____

Living Situation (Alone or with caregivers?): _____ (Describe): _____

Type of Home (House, Condo, Apt, etc.): _____ Do you have stairs in your home: _____

CONDITION/DISEASE	Y	N
Allergies		
Anemia/blood disorders		
Anxiety		
Asthma		
Arthritis		
Autoimmune Disorder		
Breathing Disorder/difficulty		
Cancer of any type		
Cardiac Pacemaker		
Chemical Dependency		
Circulation Problems		
Concussion/Head Injury		
Depression/mental health		
Diabetes		
Dizziness		

CONDITION/DISEASE	Y	N
Endocrine Disease		
Falls		
Fibromyalgia		
Fractures – recent		
Headaches/Migraines		
Hearing Impairment		
Heart disease		
Hepatitis: A, B or C		
High cholesterol		
High blood pressure		
HIV/AIDS		
Hypoglycemia		
Incontinence		
Kidney Disease		
Liver Disease		

CONDITION/DISEASE	Y	N
Lung Disease		
Neurological Disease		
Night pain		
Osteopenia		
Osteoporosis		
Parkinson's Disease		
Pregnancy		
Rheumatoid Arthritis		
Seizures/Fainting		
Stroke		
Thyroid Disease		
TMJ (jaw) disorders		
Ulcers/Stomach issues		
Urinary Tract Infection		
Other:		

Please explain any necessary details for the health concerns noted above: _____

List any surgeries and dates: _____

List any medications and dosages (or you can provide us with a list we can copy): _____

For Office Use:

Height	
Weight	
BP	
HR	
Oxy Sat	

Therapist's Notes:

History of your current condition:

What are we treating you for? _____

When did you first notice the symptoms (give a specific date if possible)? _____

Was the onset of your symptoms gradual or sudden? _____

Which of the following best describes your symptoms? (Please check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Disorientation | <input type="checkbox"/> Pain in ears |
| <input type="checkbox"/> Imbalance | <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Vertigo | <input type="checkbox"/> Nausea | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> Blurry/jumping vision | <input type="checkbox"/> Other: _____ | |

Since the onset, are your symptoms getting: Better Worse Staying the same

Are your symptoms: Constant Provoked by head movement or activity Spontaneous (without a cause)

What aggravates your symptoms? (Please check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Sitting up or laying down | <input type="checkbox"/> Going from sitting to standing |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Riding in or driving a car |
| <input type="checkbox"/> Busy environments | <input type="checkbox"/> Medications |
| <input type="checkbox"/> Other: _____ | |

Do you experience any neck pain or headaches? _____ If so, how often: _____

Rate your current neck pain: 0---1---2---3---4---5---6---7---8---9---10
No pain Worst pain

Rate your current headache: 0---1---2---3---4---5---6---7---8---9---10
No pain Worst pain

Have you had any recent medication changes? _____

Have you had any previous treatment for this condition? _____ If so, please describe: _____

Have you seen a chiropractor recently? _____

Have you had any medical tests for this condition? (X-rays, MRI, CT scan, etc.)? _____

Have you had any falls in the past year? If yes, describe the fall and frequency and if there was an injury: _____

List activities you do not do because of your symptoms _____

Is there any other pertinent information to your current condition that we should know? _____