



Patient Registration:

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

Date of Birth: _____ Home Phone: _____ Cell Phone: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

SS#(or DL#): _____ Email Address: _____

Marital Status: _____ Employer: _____

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: \$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 CONSENT AND AUTHORIZATION

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.

CANCELLATION POLICY: ARS requires 24 hours' notice to cancel an appointment. ARS reserves the right to charge a \$50 fee to any appointment that is canceled without 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 cancelations without notice, any future scheduled appointments may be automatically canceled. Management approval is required for re-scheduling on a case-by-case basis.

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). I 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.

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 consent and authorization policy above and I agree to all of the statements.

Signature of Patient or Parent/Legal Guardian

Date



General Health Questionnaire:

Patient's Name: _____ Age: _____ Today's Date: _____

Occupation: _____

Do you exercise regularly? (type and frequency) _____

Please mark yes or no on all that apply:

CONDITION/DISEASE	Y	N	CONDITION/DISEASE	Y	N	CONDITION/DISEASE	Y	N
Allergies			Endocrine Disease			Lung Disease		
Anemia/blood disorders			Falls			Neurological Disease		
Anxiety			Fibromyalgia			Night pain		
Asthma			Fractures – recent			Osteopenia		
Arthritis			Headaches/Migraines			Osteoporosis		
Autoimmune Disorder			Hearing Impairment			Parkinson's Disease		
Breathing Disorder/difficulty			Heart disease			Pregnancy		
Cancer of any type			Hepatitis: A, B or C			Rheumatoid Arthritis		
Cardiac Pacemaker			High cholesterol			Seizures/Fainting		
Chemical Dependency			High blood pressure			Stroke		
Circulation Problems			HIV/AIDS			Thyroid Disease		
Concussion/Head Injury			Hypoglycemia			TMJ (jaw) disorders		
Depression/mental health			Incontinence			Ulcers/Stomach issues		
Diabetes			Kidney Disease			Urinary Tract Infection		
Dizziness			Liver Disease			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): _____

Substance Use: (Tobacco, Alcohol, Marijuana) _____

For Office Use: (To be taken by our staff)

Height	Weight	Blood Pressure	Pulse	Oxygen Sat.	Taken by

History of your current condition:

What are we treating you for? _____

When did it start? _____

How did it happen? _____

Have you had any previous treatment for this condition? _____

Has anything helped? _____

What makes it worse? _____

Medical Tests (X-rays, MRI, CT scan, etc.)? _____

What is your goal for physical therapy? _____

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

Rate your pain:

Now:

0---1---2---3---4---5---6---7---8---9---10

No pain Worst pain

At its best:

0---1---2---3---4---5---6---7---8---9---10

No pain Worst pain

At its worst:

0---1---2---3---4---5---6---7---8---9---10

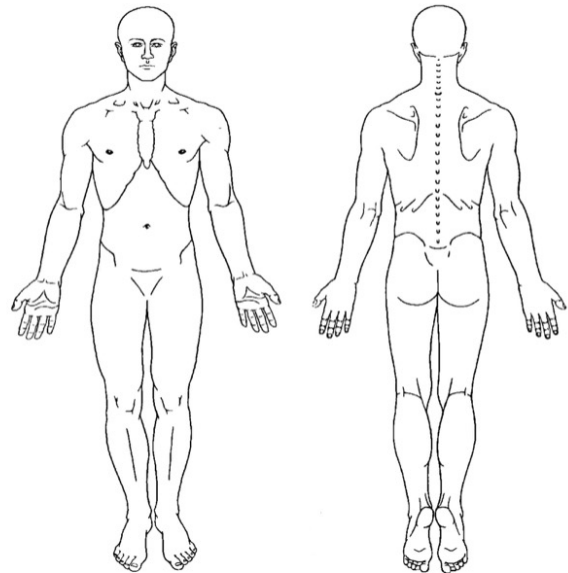
No pain Worst pain

Rate your ability to do your normal activities of life:

0---1---2---3---4---5---6---7---8---9---10

Does not limit me Unable to do anything

**Please shade the specific location of your pain
on the diagram below**



Therapist's Notes: