ADVANCED
REHABILITATION SERVICES

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: Circle Carrier: Verizon AT&T T-Mobile Other:_____
Yes	No	Email (to address provided above)
Yes	No	Phone call/voicemail message (to phone numbers provided above)

Is the reason we are treating you related to a work injury or motor vehicle accident? **YES** **NO**

Have you had a recent Home Health or Hospice care, or are you currently at a nursing home? **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:

_____ _____

_____ _____

Payment Expectations:

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***.

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 any insurance) must pay ***the full amount due*** at the end of each appointment.

_____ _____

Signature of Patient (or Parent/Legal Guardian) Date

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Patient Name:_____

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 $35 "no-show" fee to an appointment without any notice or cancellation 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

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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?_____ Is your sleep interrupted by your reason for physical therapy? _____

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: (To be taken by our staff)

Height	Weight	Blood Pressure	Pulse	Oxygen Sat.	Taken by

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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? _____ If so, please describe:_____

_____

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

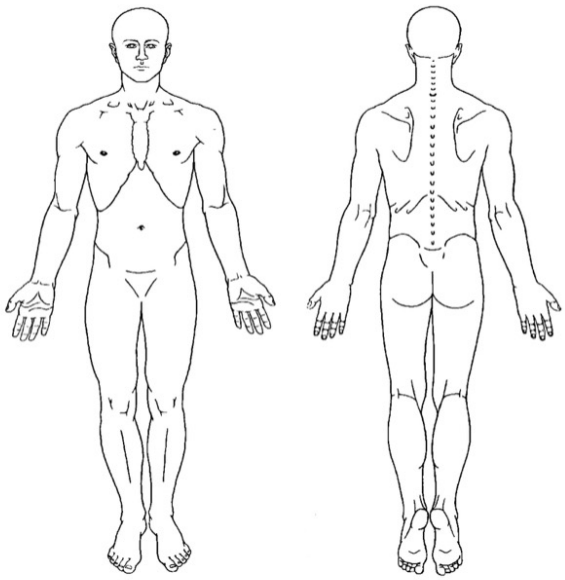
No pain Worst pain

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



Therapists Notes: