ADVANCED
REHABILITATION SERVICES

HEALTH QUESTIONNAIRE

Name _____ **Today's Date**_____

Date of Birth _____ **Age** _____ **Referring Physician** _____ **Occupation** _____

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

Alcohol Use: How many drinks do you have per week? _____ **Hand Dominance:** □ Left □ Right

Exercise: How many times a week do you exercise? _____ Type of Exercise _____

Sleep: On average, how many hours per night do you sleep? _____

Does your sleep get interrupted by the reason you are coming to physical therapy? _____

PAST MEDICAL HISTORY: Please check **yes** if you have ever been diagnosed with the following:

#*	Condition/Disease	YES
1.	Cancer of any type	
2.	Diabetes	
3.	Hypoglycemia (low blood sugar)	
4.	High blood pressure	
5.	Heart disease, chest pain, angina	
6.	Shortness of breath	
7.	Stroke	
8.	Lung disease	
9.	Kidney disease/stone	
10.	Urinary tract infection (recent)	
11.	Allergies, asthma, hay fever	
12.	Rheumatic/scarlet fever	
13.	Hepatitis ☐ A ☐ B or ☐ C	
14.	HIV/AIDS	
15.	Liver Disease (specify):	
16.	Endocrine disease	
17.	Anemia or other blood disorders	

#*	Condition/Disease	YES
18.	Neurological disease	
19.	Fainting/seizures	
20.	Migraine headaches	
21.	Osteoporosis or osteopenia	
22.	Broken bones	
23.	Arthritis or gout	
24.	TMJ (jaw) disorder	
25.	Night pain	
26.	Trauma to the head	
27.	Vision problems	
28.	Hearing problems	
29.	Dizziness	
30.	Falls	
31.	Ulcers	
32.	Stomach problems	
33.	Depression, mental health concerns:	
34.	Other:	

** Please explain any necessary details for each health concern noted above:*

_____

List any surgeries and dates_____

_____

List medications and the dosage (we can make a copy if you have a list with you)_____

_____

_____

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Name: _____ **Date:** _____

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 your condition? If so, please describe_____

_____

Has anything helped?_____

What makes it worse?_____

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

What is your goal for physical therapy?_____

Rate your pain:

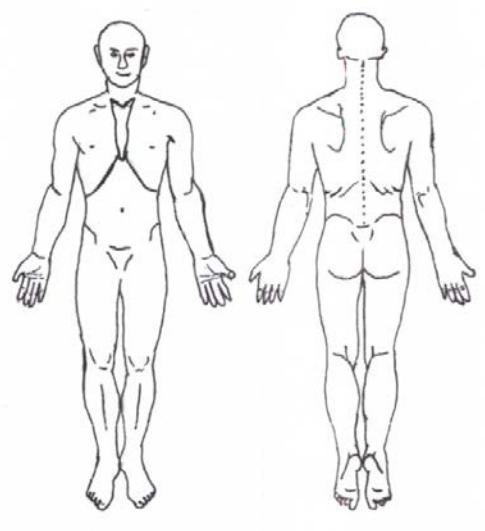
Now
0---1---2---3---4---5---6---7---8---9---10
No pain Worst pain

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 things:
0---1---2---3---4---5---6---7---8---9---10
Does not limit you Unable to do anything

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



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

_____

_____

_____

_____

_____

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PATIENT REGISTRATION: Please complete the following registration pages.

Last Name	First Name	M.I.	Date of Birth	Age	Gender

Mailing Address	City	State	Zip Code	Social Security Number

Home Phone	Cell Phone	Email Address	Driver's License # (if no SSN)

Occupation	Marital Status	Primary Care Physician	Referring Physician

Employer	Employer Address	Employer Phone

Spouse's Name	Spouse's Employer (if covered by spouse's insurance)	Spouse's Employer Phone

Emergency Contact Name	Relationship	Phone

Please complete if under age 18:

Name of Parent/Guardian	Parent/Guardian Home Phone	Parent/Guardian Cell Phone	Date of Birth

Mailing Address (if different)	City	State	Zip Code	Social Security Number

Parent/Guardian Employer	Employer Address	Employer Phone

Payment and Insurance Information (For auto accident/legal/workers' compensation, please see the next page):

- ☐ Self Payment
- ☐ Workers' Compensation
- ☐ Private Health Insurance
- ☐ Veteran's Administration
- ☐ Auto Insurance
- ☐ Legal Claim
- ☐ Medicare: Have you had a recent Home Health visit? Yes No
- ☐ Medicaid: Please give your current Passport Provider:_____

Please fill out your medical insurance information below and allow our office to make a copy for our records.

Primary Insurance Company	Policyholder's Name	Policy Number	Group

Secondary Insurance Company	Policy Number	Group

Co-Pay Amount_____ Has your deductible been met for the year? Yes No

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Injury/Accident Information (Auto/Legal/Workers' Compensation):

Date of Injury _____ Nature of Accident _____

Insurance Company to be Billed _____ Policy/Claim Number _____ Claims Adjuster/Case Manager Name _____

Insurance Company Address _____ Phone Number _____

Legal Information (If you are working with an Attorney on this claim, provide the contact information below):

Attorney's Name _____ Attorney's Address _____ Attorney's Phone Number _____

PAYMENT POLICY:
As a courtesy to you, we will bill your insurance company directly for the services rendered in a timely manner. **Co-payments are expected at the time of service** in accordance with your health insurance policy and benefits. If you are paying for services on your own ("self-pay"), we require payment at the time of service unless prior arrangements are made with our office. **There will be a 1.5% per month (18% APR) finance charge on any unpaid balance.**

NOTICE OF PRIVACY PRACTICES FOR MY PROTECTED HEALTH INFORMATION:
I have been offered and/or given a copy of this 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, Jolene Gibbs, at (406) 752-7250 if I have further concerns.

Initials _____ **Date** _____

AUTHORIZATION:
I authorize the release of any information acquired in the course of my treatment to my insurance carrier and physician. I authorize payment of medical benefits directly to Advanced Rehabilitation Services, LLC for services rendered. 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.

Signature of Responsible Party (must be over 18 years old) _____ **Date** _____

AUTHORIZATION FOR TREATMENT OF A MINOR:
I authorize Advanced Rehabilitation Services, LLC to provide the appropriate care and treatment for the minor named above. This authorization allows the physical therapists to treat the minor if/when I am not present for the treatment for the duration of this plan of care.

Signature of Parent/Guardian _____ **Date** _____

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PAYMENT AND CANCELLATION/NO-SHOW POLICIES

The following are our policies regarding payment, cancellations, and no-shows. While we understand that situations arise that require you to reschedule your appointments, consistent attendance to physical therapy can greatly improve your potential outcome. Often, we have patients who are hoping to be worked into the schedule if a cancellation arises. Advanced notice allows us to fill your appointment slot.

1. If you have an insurance co-pay, we are contractually obligated by your insurance company to collect it at the time of your visit.

2. If you are paying for services on your own ("self-pay"), we require payment at the time of service unless prior arrangements are made with our office.

3. We request 24 hours' notice in the event of a cancellation. When you call in to cancel, please let us know the reason for cancelling, so that we can pass the message along to your therapist. Be prepared with an alternative time to reschedule to ensure you get the appropriate amount of treatment.

4. A $35 deposit may be required to reserve you next appointment in the event of repeated cancel/no-show without proper notice. This charge will not be billed to your insurance company, but will have to be paid by you personally prior to the start of your next treatment. If you attend all subsequent appointments, this fee will be applied to your final balance or refunded if there is no balance after all charges have been processed and paid.

5. No-shows to appointments and cancellations without proper notice and are documented in your medical record and may jeopardize claims with your insurance or third party payer.

Thank you for your understanding in this matter.

_____ _____

Patient Signature Date

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Appointment Reminder Consent

Please complete this form granting Advanced Rehabilitation Services, LLC permission to provide automatic appointment reminder notification to you by email or text message if you choose. ***If you prefer to be called, please select that choice.***

Check ONE box:

☐ Advanced Rehabilitation Services may send me text messages to confirm my upcoming appointments.

I recognize that normal text messaging rates may apply.

Please select your cell phone provider:

□ Verizon

□ AT&T

□ Other _____

☐ Advanced Rehabilitation Services may send me email messages to confirm my upcoming appointments.

Email address: _____

☐ Advanced Rehabilitation Services may call me and/or leave a message to confirm my upcoming appointments.

Email and Text Communication Policy:

If you choose to communicate with our staff using email or text message concerning your care, Advanced Rehabilitation Services, LLC has reasonable safeguards in place for your protected health information (PHI). By signing below, you consent to sending and receiving information regarding your care via text and/or email. You accept the inherent risks of submitting information electronically. As per HIPAA guidelines, our company is required to notify you in the event your protected health information (PHI) is compromised.

_____

Patient Name

_____ _____

Signature of Patient or Parent/Guardian Date

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Consent to Receive Physical Therapy

By signing below and attending my physical therapy appointments, I consent to the evaluation and treatment performed by my licensed physical 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 and therapeutic exercise. My treatment plan will be based on my current presentation and the best judgement of my physical therapist.

Serious complications or injuries resulting from physical therapy procedures are very rare and all risks will be carefully managed by your physical 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.

I understand that there are inherent risks associated with participation in Physical Therapy and will address any specific concerns or questions with my Physical Therapist during my appointment. I understand that I have the right to terminate any part of my physical therapy treatment at any time.

_____ _____

Signature of Patient/Responsible Party (must be over 18 yrs) Date

_____

Printed Name

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