



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:

Table with 3 columns: #*, Condition/Disease, YES. Rows 1-17 listing various medical conditions.

Table with 3 columns: #*, Condition/Disease, YES. Rows 18-34 listing various medical conditions.

* 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) _____

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:

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

Now

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

At its best

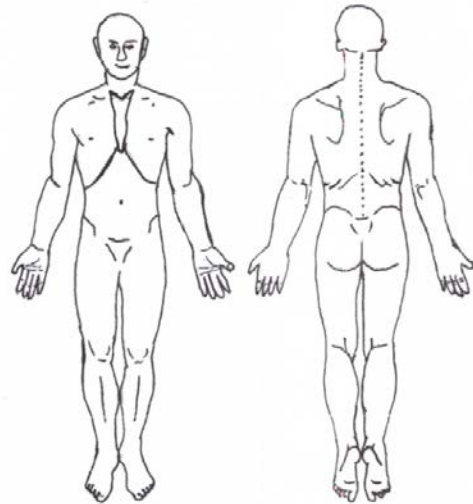
0---1---2---3---4---5---6---7---8---9---10
No pain Worst pain

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



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



Achieve • Restore • Stay Active

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

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		

Advanced Rehabilitation Services

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
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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
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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
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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 your 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



Appointment Reminder Consent & Policy

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.)

Initial ONE line:

___ Advanced Rehabilitation Services may send me email messages to remind me of my upcoming appointments.
Email address: _____

___ Advanced Rehabilitation Services may call me and/or leave a message (if needed) to confirm my upcoming appointments.

___ **AT&T customers only:** Advanced Rehabilitation Services may send me text messages to remind me of my upcoming appointments. *I acknowledge that normal text messaging rates may apply.*

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.

Consent to Receive Occupational Therapy

By signing below and attending my occupational therapy appointments, I consent to the evaluation and treatment performed by my licensed occupational therapist. The treatment procedures may include manual therapy, heat/ cold therapy, high/ low amplitude velocity mechanical traction, ultrasound, laser therapy, electrical stimulation, neuromuscular re-education, therapeutic exercises, and compensatory techniques for any unresolved functional issues. My treatment plan will be based on my current presentation and best clinical judgment of my occupational therapist.

Serious complication or injuries resulting from occupational therapy procedures are very rare and all risks will be carefully managed by your occupational therapist. Possible risks, include but are not limited to, an increase in pain, bruising, burns, cardiovascular complications, bone fracture, infection or nerve injury.

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

Signature of Patient or Parent/Guardian

Date

• Tim Gibbs, PT, OCS, Cert. MDT, CCTT, CMTPT • Brian Miller, PT, MS, OCS, CMTPT • Lynnell Finley, PT, CMTPT, Cert. LSVT BIG • Tracie Schroeder, PT, DPT, ATC, CMTPT • Kristin Stockham-Baller, PT, DPT, CMTPT, PRPC • Doug Snyder, PT, CMTPT • Libby Bergman PT, DPT, OCS, FAAOMPT, MTC • Marlesa Moore, PT, DPT • Debra Sullivan, PT, CMTPT • Dianne Miklos, OTR/L, CHT, CLT •

175 Commons Loop, Suite 100 • Kalispell, MT 59901 • Phone 406.752.7250 • Fax 406.752.6250 • www.arspt.com