



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

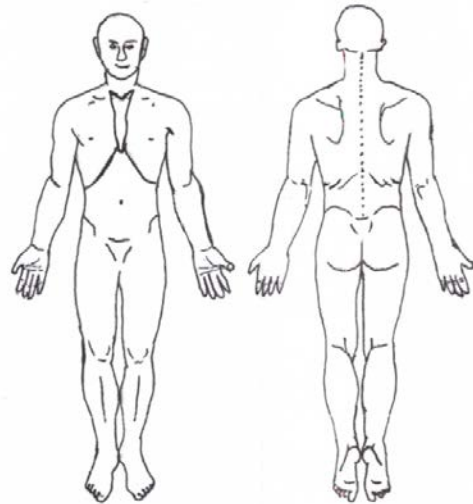
0---1---2---3---4---5---6---7---8---9---10
No pain Worst pain

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? _____



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 (or DL #)	
_____	_____	_____			
Home Phone	Cell Phone	Email Address			
_____	_____	_____	_____		
Occupation	Marital Status	Primary Care Physician	Referring Physician		
_____	_____			_____	
Employer	Employer Address	Employer Phone			
_____				_____	
Spouse's Name	Spouse's DOB				
_____	_____				
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 (or DL #)
_____	_____			_____
Parent/Guardian Employer	Employer Address	Employer Phone		

AUTHORIZATION:

I authorize payment 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, including 15% interest on all balances not paid within thirty (30) days of invoice date or maximum extent allowed by state and federal law.

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

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 •



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 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

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, Jenn Reynolds, at (406) 752-7250 if I have further questions.

Initials

Date

PAYMENT AND INSURANCE INFORMATION:

Medicare: Have you had a recent home health visit? YES NO

Medicaid: Please give your current Passport Provider: _____

- Self payment Veterans Administration
- Workers' compensation Auto Insurance
- Private health insurance Legal Claim

Please fill out your medical insurance information below if a copy of your card has not been obtained by our office.

Primary Insurance Company

Secondary Insurance Company

**Legal Information (If you are working with an Attorney on this claim, provide the contact information below.)
By providing the Attorney contact information, you authorize our office to contact them directly.**

Attorney's Name

Attorney's Address

Attorney's Phone Number

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

Date of Injury Nature of Accident

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

Insurance Company Address Phone Number

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:

Signature of Patient (or Legal Representative)

Date

Print Name



COMMUNICATION & 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.)

- Advanced Rehabilitation Services may call me to confirm my upcoming appointments.
Advanced Rehabilitation Services may leave a message on my voicemail if I do not answer the call.
Advanced Rehabilitation Services may send me email messages to remind me of my upcoming appointments.
Email address:

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.

By providing your phone number(s) and/or email address, you consent to receive communication from our clinic using these methods to communicate with you regarding your care. 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 electronically, and you accept the inherent risks of submitting information electronically. Pursuant to HIPAA guidelines, our company is required to notify you in the event your 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, therapeutic activities 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, including benefits, risks, and alternatives. I understand that I have the right to terminate any part of my occupational therapy treatment at any time. I understand that no guarantees have been made regarding the outcome of the treatments provided.

By signing below, I hereby acknowledge and agree that I have completely read and fully understand, and agree to be bound by the Appointment Reminder Consent & Policy, as well as the Consent to Receive Occupational Therapy as described herein.

Signature of Patient or Parent/Guardian

Date

Print name of Patient

Print name of Parent/Guardian (if applicable)



CANCELLATION & NO-SHOW POLICY

We require twenty-four (24) hours notice in the event of a cancellation. We have patients on a wait list in case of cancellations. Advanced cancellation notice allows us to fill your appointment slot. Please be aware that best outcomes through physical therapy are achieved by consistent and regular attendance.

Please note that if your insurance requires prior authorization for treatment, cancelling or not showing may affect your ability to schedule future appointments. Cancellations within twenty-four (24) hours or no-shows are documented in your medical record, and may jeopardize claims with your insurance or third party payer.

There is a thirty-five dollar (\$35) charge for a no-show or cancellation without twenty-four (24) hours notice (“Cancellation Fee”), which must be paid prior to your next treatment. This charge will not be billed to your insurance company. By signing below, you understand the Cancellation and No-Show Policy and expressly agree to be charged and pay the Cancellation Fee as stated herein.

PAYMENT POLICY

As a courtesy to you, we will bill your insurance company directly for the services rendered in a timely manner. Please be advised, you are responsible for knowing your insurance benefits, and are responsible for any payment due not covered by your insurance. If you have an insurance co-pay, we are contractually obligated by your insurance company to collect it **at the time of your visit.**

An account payment is due at the time of service for patients with a deductible commercial insurance plan of \$1,000 or more who have not met their deductible. Account payments are required at check in as follows:

Evaluation: \$200

Regular Treatment: \$125

If you do not have health insurance, and are paying for services on your own (“self-pay”), we require payment in full at the time of service unless prior arrangements are made with our office.

Monthly statements are mailed at the beginning of each month. Payment in full is due upon receipt. There will be a 1.25% per month (15% APR) finance charge on any unpaid balance.

Payments may be processed electronically. A receipt may be sent to your email or through text which may contain protected health information. By using our electronic payment method, you consent to receive electronic receipts, and accept the inherent risks for submitting information electronically. Pursuant to HIPAA guidelines, we will notify you in the event your protected health information is compromised.

By signing below, I hereby acknowledge and agree that I have completely read and fully understand, and agree to be bound by the Cancellation and No-Show Policy, as well as the Payment Policy as described herein.

Signature of Patient or Parent/Guardian

Date

Print name of Patient

Print name of Parent/Guardian (if applicable)