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

Reason for your referral _____

_____

Which of the following best describes your symptoms? (Please check all that apply):

☐Difficulty walking	☐Headaches	☐Pain in ears
☐Imbalance	☐Pain in neck region	☐Ringing in ears
☐Staggering	☐Lightheadedness	☐Hearing loss
☐Sense of leaning/tilting	☐Disorientation	☐Blurry/jumping vision
☐Vertigo (spinning events)	☐Weakness	☐Poor concentration/memory

☐Other: _____

When did you first notice the symptoms (please give a specific date if possible)?_____

_____

Was the onset of your symptoms gradual or sudden?_____

Since the onset, are your symptoms getting (please check one): ☐Better ☐Worse ☐Not changing

Are your symptoms: ☐Constant ☐Provoked by head movement or activity ☐Spontaneous

What aggravates your symptoms? (Please check all that apply):

☐Lying down	☐Going from sitting to standing	☐Walking
☐Riding in or driving a car	☐Visual motion	☐Medication

☐ 0ther:_____

Have you had any falls in the past year? If yes, describe the fall and frequency_____

_____

_____

Have you had any vestibular testing? If yes, please list _____

_____

List activities you do not do because of your symptoms _____

_____

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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 (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**

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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 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
□ Workers' compensation
□ Private health insurance
☐ Veterans Administration
□ Auto 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

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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

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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)

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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 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, therapeutic exercise and therapeutic activities. My treatment plan will be based on my current presentation and the best clinical 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. 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 Physical Therapy as described herein.

_____ _____

Signature of Patient or Parent/Guardian Date

_____ _____

Print name of Patient Print name of Parent/Guardian (if applicable)

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