ADVANCED
REHABILITATION SERVICES

PATIENT CONSENT AND AUTHORIZATION

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, lymphedema management and educati. on, 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.

CANCELLATION POLICY: ARS requires 24 hours' notice to cancel an appointment. ARS reserves the right to charge a $50 fee to any appointment that is canceled without 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 cancelations without notice, any future scheduled appointments may be automatically canceled. Management approval is required for re-scheduling on a case-by-case basis.

COMMUNICATION & APPOINTMENT REMINDER CONSENT: By providing my phone number(s) and/or email address, I consent to receive communication from the clinic using texts, emails or voicemails regarding 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). I 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.

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, Jolene Gibbs, at (406) 752-7250 if I have further questions.

I have reviewed the consent and authorization policy above and I agree to all of the statements.

_____ _____

Signature of Patient or Parent/Legal Guardian Date

Please fill out backside →

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Patient Registration:

Last Name:_____ First Name_____ M.I._____ Gender:_____

Date of Birth:_____Home Phone:_____ Cell Phone:_____

Mailing Address:_____ City:_____ State:_____ Zip Code:_____

SS#(if applicable for insurance):_____ Email Address:_____

Marital Status: _____ Employer:_____

Primary Care Physician:_____ Referring Physician:_____

Emergency Contact Information:

Name:_____ Relationship:_____

Phone:_____

Appointment Reminders: *Our clinic sends out automatic text reminders the day prior to your scheduled appointment with the date, time and the treating therapist. If you want to opt out of text reminders and get a phone call reminder instead, please check the box below.*

☐ I do NOT want text reminders. Please call and leave a voice mail reminder instead.

Are we treating you for a work injury or motor vehicle accident *with an open claim?* **YES** **NO**

Have you recently received Home Health, Hospice or nursing home care? **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:
_____	_____
_____	_____

Financial Responsibility:

You are responsible for any services rendered at Advanced Rehabilitation Services. As a courtesy, we will bill your insurance provided. However, any expenses not covered by insurance must be paid in full.

Co-pays: 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***.

Deductible of $1000 or more: 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: $200 **Follow up visits: $125**

Self Pay Patients: (without insurance) must pay ***the full amount due*** at the end of each appointment according to our Self Pay Fee Schedule, which is available in writing upon request in compliance with the Good Faith Estimate.

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General Health Questionnaire:

Patient's Name:_____ Age:_____ Today's Date:_____

Occupation:_____

Do you exercise regularly? (type and frequency) _____

Please mark yes or no on all that apply:

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):_____

_____

Substance Use: (Tobacco, Alcohol, Marijuana) _____

For Office Use: (To be taken by our staff)

Height	Weight	Blood Pressure	Pulse	Oxygen Sat.	Taken by

Please fill out backside →

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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? _____

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

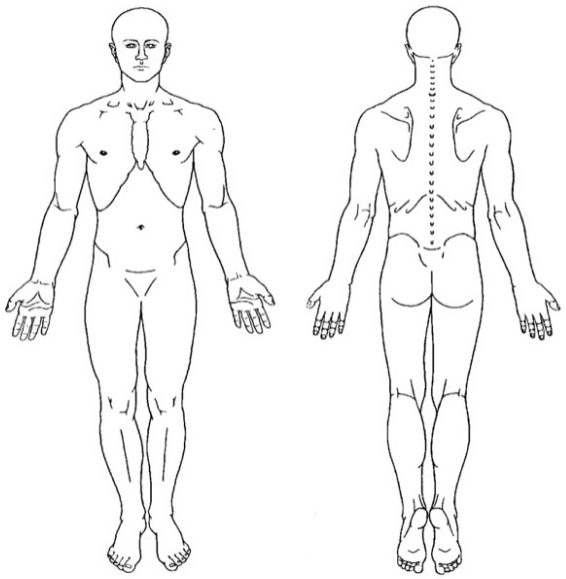
No pain Worst pain

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



Therapist's Notes: