ADVANCED
REHABILITATION SERVICES

General Health Questionnaire:

Today's Date:_____

Patient's Name:_____ Date of Birth:_____ Age:_____

Referring Physician:_____ Hand Dominance: Left Right

Occupation:_____ Able to work with this problem?_____

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

Exercise: Type of Exercise:_____ How often:_____

Sleep: Hours of sleep per night?_____ Sleep interrupted by your reason for coming to physical therapy?_____

Living Situation: __ Live alone __ Live with family/caregivers (Describe):_____

Type of Home (House, Condo, Apt, etc.):_____ Do you have stairs in your home:_____

CONDITION/DISEASE	Yes	CONDITION/DISEASE	Yes	CONDITION/DISEASE	Yes
Allergies		Endocrine Disease		Lung Disease	
Anemia/blood disorders		Falls		Neurological Disease	
Anxiety		Fibromyalgia		Night pain	
Asthma		Fractures – recent		Osteopenia	
Arthritis		Headaches/Migraines		Osteoporosis	
Autoimmune Disorder		Hearing Impairment		Parkinson's Disease	
Breathing Disorder/difficulty		Heart disease		Pregnancy	
Cancer of any type		Hepatitis: A, B or C		Rheumatoid Arthritis	
Cardiac Pacemaker		High cholesterol		Seizures/Fainting	
Chemical Dependency		High blood pressure		Stroke	
Circulation Problems		HIV/AIDS		Thyroid Disease	
Concussion/Head Injury		Hypoglycemia		TMJ (jaw) disorders	
Depression/mental health		Incontinence		Ulcers/Stomach issues	
Diabetes		Kidney Disease		Urinary Tract Infection	
Dizziness		Liver Disease		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):_____

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

Height	Weight	Blood Pressure	Pulse	Oxygen Sat.	Taken by

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History of your current condition:

What are we treating you for?_____

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

Was the onset of your symptoms gradual or sudden?_____

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

- ☐ Difficulty walking
- ☐ Imbalance
- ☐ Vertigo
- ☐ Blurry/jumping vision
- ☐ Disorientation
- ☐ Poor concentration
- ☐ Nausea
- ☐ Other: _____
- ☐ Pain in ears
- ☐ Ringing in ears
- ☐ Hearing loss

Since the onset, are your symptoms getting: ☐ Better ☐ Worse ☐ Staying the same

Are your symptoms: ☐ Constant ☐ Provoked by head movement or activity ☐ Spontaneous (without a cause)

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

- ☐ Sitting up or laying down
- ☐ Walking
- ☐ Busy environments
- ☐ Other: _____
- ☐ Going from sitting to standing
- ☐ Riding in or driving a car
- ☐ Medications

Do you experience any neck pain or headaches?_____ If so, how often: _____

Rate your current neck pain: 0---1---2---3---4---5---6---7---8---9---10

No pain Worst pain

Rate your current headache: 0---1---2---3---4---5---6---7---8---9---10

No pain Worst pain

Have you had any recent medication changes? _____

Have you had any previous treatment for this condition? _____ If so, please describe:_____

_____

Have you seen a chiropractor recently? _____

Have you had any medical tests for this condition? (X-rays, MRI, CT scan, etc.)?_____

_____

Have you had any falls in the past year? If yes, describe the fall and frequency and if there was an injury:_____

_____

List activities you do not do because of your symptoms _____

_____

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

_____

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Patient Registration:

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

Date of Birth:_____ Age:_____ Marital Status: _____ SS#(or DL#):_____

Mailing Address:_____ City:_____ State:_____

Home Phone:_____ Cell Phone:_____ Zip Code:_____

Email Address:_____ Spouse's Name (if applicable):_____

Occupation:_____ Employer:_____

Employer Address: _____Employer Phone:_____

Primary Care Physician:_____ Referring Physician:_____

Emergency Contact Information:

Name:_____ Relationship:_____

Phone:_____

Parent or Legal Guardian Information (*if patient is under the age of 18*):

Name:_____ Relationship:_____ Date of Birth:_____ Gender:_____

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

Phone:_____ SS# (or DL#):_____

Employer:_____ Employer Phone:_____

Financial Guarantor:_____ Relationship:_____

Appointment Reminders: *Please indicate which methods of communication you prefer.*

Yes	No	Email (to address provided above)
Yes	No	**For AT&T customers only** - text messaging (standard rates may apply)
Yes	No	Phone call/voice mail message (to phone numbers provided above)

Payment Expectations:

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**.

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 balance on your account at the check in of each visit as follows:

Evaluation: $200 **Regular Treatment: $125**

Self Pay Patients: (without any insurance) must pay the **full amount due** at the end of each appointment.

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Patient Name:_____

Health Insurance Information: *Please present your photo ID and Health Insurance Card(s)*

Primary Insurance:_____ Secondary Insurance:_____

Subscriber Name:_____ Subscriber Name:_____

Subscriber Date of Birth:_____ Subscriber Date of Birth:_____

Medicare Beneficiaries: Have you had a recent Home Health or Hospice visit? **Yes** **No**

Recent hospitalization? **Yes** **No**

Medicaid Beneficiaries: Current Passport Provider:_____

Accident Insurance Information if applicable: *(Auto/Legal/Workers' Compensation)*

Date of Injury:_____ **Nature of Accident:** _____

Insurance Company to be billed: _____ Claim Number: _____

Insurance Company Address: _____

Claims Adjuster/Case Manager Name: _____ Phone Number: _____

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 Phone Number: _____

Attorney's Address: _____

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 Parent/Legal Guardian) Date

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Patient Name:_____

PATIENT CONSENTS AND AUTHORIZATIONS

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

AUTHORIZATION OF INSURANCE PAYMENT AND FINANCIAL RESPONSIBILITY: I authorize payment directly to Advanced Rehabilitation Services, LLC for services rendered. I understand it is my responsibility to know my insurance benefits and how physical 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 maximum extent allowed by state and federal law. ARS reserves the right to refuse treatment to any person with outstanding balances that have not made attempts to pay balance due.

AUTHORIZATION FOR TREATMENT OF A MINOR (IF APPLICABLE): 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. The parent or legal guardian accepts full responsibility for payment in full for this account.

COMMUNICATION & APPOINTMENT REMINDER CONSENT: By providing my phone number(s) and/or email address, I consent to receive communication from the clinic using these methods to communicate with me 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). By signing below, I consent to sending and receiving information regarding my care electronically, and 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.

CANCELLATION POLICY: ARS requires 24 hours notice in the event of a cancellation. ARS reserves the right to charge a $35 fee for a "no-show" to an appointment without any notice or cancellation without 24 hours notice ("Cancellation Fee"). This charge will not be billed to my insurance company. By signing below, I expressly agree to be charged and pay the Cancellation Fee prior to the start of my next treatment visit.

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

I have reviewed the consents and policies above and I agree to all of the statements.

_____ _____

Signature of Patient or Parent/Legal Guardian Date