Advanced Rehabilitation Services, LLC

Specializing in Vestibular, Spinal, Orthopedic and TMJ Physical Therapy

PATIENT INFORMATION FORM

PLEASE PRINT AND COMPLETE ALL ENTRIES

Patient Name (First, Middle, Last)________________________________ Date of Birth____/____/____

Street Address________________________________ Email Address________________________

Mailing Address________________________________ Home Phone________________________

City__________________ State________ Zip Code__________ Cell Phone________________

Social Security Number__________________ Marital Status__________ Age______________

Employer________________________________ Occupation________________________________

Employer Address________________________________ Business Phone Number______________

Spouse's Name__________________ Phone__________ Employer______________________

Accident Related?______________ Nature of Accident________________________________

Date of Injury____/____/____ Nature of Problem________________________________

Primary Care Physician__________________ Referring Physician________________________

Emergency Contact__________________ Relationship__________ Phone______________

RESPONSIBLE PARTY INFORMATION (i.e. parent or guardian)

Name________________________________ Date of Birth____/____/____ Phone______________

Address (if different) ________________________________ S.S. # ______________

Employer________________________ Employer Address________________________________

ACCOUNT TYPE (select):

Self Pay   Health Insurance   Workman's Comp   Veteran's Administration   Auto Insurance   Legal

Medicare (Have you had a recent Home Health Care visit?   Yes   No)   Medicaid (Passport Provider Name)______________

Primary Insurance __________________ Policy #______________ Group__________

Secondary Insurance __________________ Policy #______________ Group__________

Co-Pay Amount__________ Has your deductible been met for the year?   Yes   No

ACCIDENT INFORMATION (If applicable)

Insurance Company we will be billing:__________________ Policy/Claim # ______________

Address________________________ Adjuster______________ Phone______________

PAYMENT IS DUE AT THE TIME OF SERVICE. Co-payments are expected at the time of service in accordance with your health insurance policy and benefits. There will be a 1.5% per month (18% APR) charge on any unpaid balance.

NOTICE OF PRIVACY PRACTICES OF 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____/____/____

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________________________________ Date____/____/____

Tim Gibbs, PT, OCS, Cert. MDT, CCTT · Brian Miller, PT, MS, OCS
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HEALTH QUESTIONNAIRE

Name________________________________ Today's Date____/____/____ Date of Birth____/____/____ Age__________

Occupation____ Referring Physician___________________________

Dominant Hand (check one): Right handed Left handed

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

Alcohol: How many drinks do you have each week?__________

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? : Yes No Do you wake in the morning feeling rested? : Yes No

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	
11.	Asthma, hay fever	
12.	Rheumatic/Scarlet Fever	
13.	Hepatitis/HIV/AIDS or Liver Disease	
14.	Ulcers or stomach problems	
15.	Endocrine Disease	

#*	Condition/Disease	YES
16.	Anemia or other Blood Disorders	
17.	Depression, mental health concerns	
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 or Hearing Problems	
28.	Dizziness	
29.	Falls	
30.	Other:	

* Please explain any necessary details for each health concern noted above (example: #1 – skin cancer)

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List any Surgeries and Dates____

____

List Medications (we can make a copy if you have a list with you)________________________

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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 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:

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

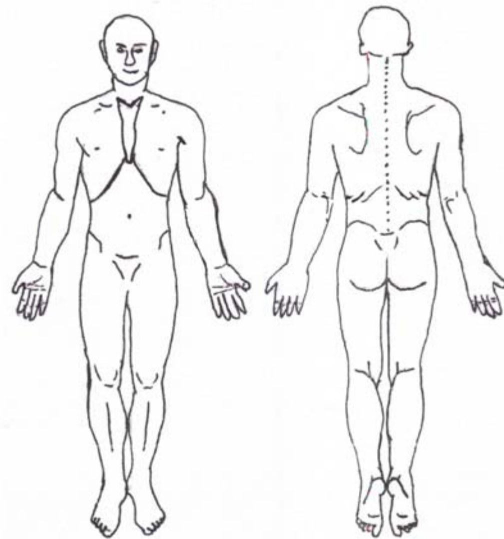
At its worst

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

For patient's filling out this form on their computer, please click and drag the red X's and place them over the specific locations of your pain. Otherwise, please shade the areas manually after printing it out.



Is there anything other information that is important to your current condition that we should know? ____________________

____

____

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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. You will work directly with your physical therapist to determine the appropriate frequency for your appointments.

- If you have an insurance co-pay, we are contractually required by your insurance company to collect it at the time of your visit.
- 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.
- We require 24 hours' notice in the event of a cancellation. We ask when you call in, to have an alternative time in mind that will ensure you get the fully prescribed number of treatments that week.
- There is a $35 charge for a cancellation/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 your next treatment.
- For Worker's Compensation and motor vehicle accident patients, we are required to document any missed appointments. All notes are forwarded to your case manager and could jeopardize your claim.
- If you feel it is time to decrease the frequency of visits, please discuss this with your therapist at your next appointment.

Thank you for your understanding in this matter. 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.

______________________________ ____________________

Patient signature **Date**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

We understand that medical information about you and your health is personal. We are committed to protecting this information. We keep a medical file to improve the quality of your care, and for certain legal requirements.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

1. For Treatment: People in our office and from your doctor's office may have access to your file.
2. For Payment: Many insurance companies require medical information in order to process your claims. We may visit with your case manager/claims examiners unless you specifically ask us to do otherwise.
3. If requested by family/guardians: We will share information with family members and guardians unless you specifically ask us to do otherwise.
4. For appointment reminders: We may call you to remind you of appointments or to inquire about your health status and leave a message at the number you provide to us.
5. As required by law: We honor subpoenas and other legal requirements to release medical information.
6. If you sign a release asking us to send information to anyone else.
7. During treatments: You may be exercising or receiving treatments with other patients in the vicinity.

YOUR RIGHTS REGARDING OUR MEDICAL FILES:

1. Right to copy and inspect. You have the right to copy and inspect your medical file. Copies are provided for $0.15 per page.
2. Right to amend. If you believe that information in your record is incorrect or if important information is missing, you may ask us to amend the information.
3. Please submit your request in writing to your therapist, and state the reasons for your request.
4. Right to an accounting of disclosures. You have a right to receive a list of instances where we have disclosed information about you for reasons other than treatment or payment.

If you would like us to make exceptions to this policy, please ask.

______________________________ _________________________

Patient's signature Date

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