

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 ____ / ____ / ____

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VESTIBULAR HEALTH QUESTIONNAIRE

Name _____ Today's Date ____ / ____ / ____ Date of Birth ____ / ____ / ____ Age ____

Occupation _____ Referring Physician _____

Dominant Hand (check one): Right handed Left handed

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

Exercise: How many times a week do you exercise? _____ Type of exercise _____

Living Situation: (check one) Live alone Live with family/caregivers

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

List any Surgeries and Dates _____

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

HISTORY OF YOUR CURRENT CONDITION

Reason for you 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? lying down going from sitting to standing walking
riding in or driving a car visual motion medication Other _____

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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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

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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