PATIENT INFORMATION

(Please print carefully)

Date: ________________

Patient Name: ____________________________________ Birth Date: __________ Male Female

Address: _____________________________________City: _______________ State: _____ Zip: ______

Home Phone:________________ Work Phone: ____________________ Cell Phone: _____________

Email Address: ____

Best for Appointment reminders (circle one): Cell Phone text Cell Phone call Email Home Phone

Work Title & Responsibilities: ____

Please Circle: Full Time Part Time Medical Leave Disabled Retired None

If under 18, Parent/Guardian's name: ________________________________DOB: _______________

Person to contact in case of an emergency: ________________ Relationship: __________________

Emergency contact phone: _________________________________

It is okay to leave a message on your voicemail? _____________ Yes/No

How did you hear about us? Website __ ; Doctor referral __ ; Friend/Relative__ ; Other _______________

Insurance Information (circle one)

Private Insurance Worker's Compensation Motor Vehicle Accident Medicare Private Pay

Name of Insured: ______________________________Relationship to patient ___________ Birth Date: ______

Name of Employer: _____________________________ Work Phone: _________________

Insurance Company: ____________________________ ID/Claim# ________________ Group# _______________

Insurance Co Address: ______________________________City: ___________________ State: ____ Zip: _______

Contact Phone Num: _____________________________ Name (if applicable): _________

Do you have secondary insurance? YES NO If Yes, please provide details to front desk.

History of Present Physical Issues:

Primary Care Physician: ____ Phone: ______________

Referring Physician: ____ Phone: ________________

Chief Complaint/Injury: ____________________________ Date of Injury: ____________Date of Surgery: __________

HEALTH HISTORY

Have you ever had the following (Circle Answer for each)

Asthma/Emphys./COPD	yes	no	Seizures/Epilepsy	yes	no	Bleed tendency	yes	no
Diabetes, I or II	yes	no	Hepatitis B or C	yes	no	Polio	yes	no
Heart Disease	yes	no	AIDS/HIV	yes	no	Cancer	yes	no
Pacemaker	yes	no	Arthritis	yes	no	Kidney Disease	yes	no
Stroke	yes	no	Tuberculosis	yes	no	Rheumatic Fever	yes	no
			Taking Blood Thinner	yes	no			

Blood Pressure HIGH LOW NORMAL

Taking Blood Pressure Meds. yes no

Are you pregnant or actively trying for pregnancy? Yes No

Previous Hospitalizations, Surgeries, Serious Illness, Other ____________________

____________________ When: ____________________

Medications/supplements: ____________________

Allergies: ____________________

Date of Injury or Onset of Symptoms and Description: ____________________

____

Please Circle: New Injury Chronic Recurring Progressive Not sure of Cause

Please Circle all that Apply: Sharp Dull Aching Sore Stabbing Radiating Throbbing

Burning Weakness Stiffness Cramping Numbness

Rate Your Level of Pain: 0 = None 1-3 = Mild Pain 4-6 = Moderate Pain 7-9 = Severe Pain

Rate how your symptoms interfere with your daily activities:

0% = Not at all, 10-30% = Mild, 40-60% = Moderate, 70-90% = Severe, 100% = Completely

List any Sports and/or Recreation you enjoy: ____________________

List any other health concerns you have: ____________________

I authorize the release of any information concerning my (or my child's) health care and treatment provided for the purpose of evaluating and administering claims of insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me, directly to Alpine Therapy LLC. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform this office of any changes in my medical status or my health insurance. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of Patient, Parent or Guardian: ____________________ Date: ________

Financial Policy

Alpine Therapy strives to provide the best care to you and your family. In doing so, we provide assistance to you in filing medical insurance claims in order to receive maximum benefit allowed by your health insurance carrier. *Therefore, it is your responsibility to provide us, at the time of your initial evaluation, with complete and accurate insurance information.* If you do not have medical insurance, our staff will provide you with information regarding different options. The following is a statement of our financial policy; we require you to read, agree to, and sign *prior to any non-emergency treatment.*

All patients must complete our Patient Information Form before seeing the therapist.

Current insurance card and information must be provided upon check-in. If you have changed insurance companies, you must provide us with the new information as soon as possible.

Co-payments, co-insurance and deductibles must be paid at time of service. We accept cash, checks, Visa and MasterCard.

Please note: All deductibles and co-payments are contractual agreement between you and your insurance company.

Insurance Responsibility:

Your insurance company has developed maximum fee schedules for rehabilitation and other services. These schedules are internal to your insurance company and they may or may not cover all charges incurred during your treatment. The fee schedules often do not reflect standard charges in our area. Any charges not covered or any differences remaining following payment by your insurance company will be considered patient responsibility. We are not responsible for knowing exactly what physical therapy treatments and procedures your policy/plan covers. To verify what exactly is covered or if you do not feel that your insurance company has made adequate payment in your account, please contact your insurance company.

Referral Policy:

If your insurance carrier requires a REFERRAL before seeing specialists, you are ultimately responsible for ensuring that the appropriate referral has been completed from your primary care physician to our office prior to your initial visit.

No Show/ Cancelation Policy:

Our goal is to accommodate our patients' health care needs and their schedules to the best of our ability. For this reason, we request a 24- hour notice of cancellation, so that your appointment time may be offered to another patient in need.Please understand that we still pay our staff even when you don't come to your appointment.

If you do not show up for your appointment or if you fail to cancel 24 hours in advance, we will charge $40.00 to partially cover expenses.

If we must send your account to collections for unpaid bills, we reserve the right to charge an additional 25% of your account balance to cover collection fees.

I have read, fully understand, and agree to all terms set forth in the above Financial Policy. I have been informed that my insurance benefits are of a "usual and customary" type and understand the meaning of this.

Responsible Party (Please Print Name): ____

Signature: ____ Date: _________________________

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1566 Vista ViewDrive • Longmont, CO 80504 • Phone: 720-266-7100

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly;**
- **Obtain payment from third party payers**
- **Conduct normal healthcare operations, such as quality assessments and physician certifications;**

If I determine it is necessary, I will read the *Notice of Privacy Practices,* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time, at the address above, to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name(print): ____

Relationship to Patient (if patient under 18): ____________________________________

Signature: ____ **Date:** _____________