Alpine Physical Therapy LLC

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: _____ Employer 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

Blood Pressure HIGH LOW NORMAL Taking Blood Thinner yes no

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 Physical 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 Physical 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:** _____