TETON THERAPY

# PATIENT INFORMATION FORM

## Patient Information

Last Name _____ First Name _____ SSN _____

Date of Birth _____ Gender _____ Marital Status _____

Address _____

City _____ State _____ Zip _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Email _____

REMINDER (circle one): Text ◯ Email ◯ Call ◯ If text, list your cell provider: _____

## Emergency Contact

Last Name _____ First Name _____

Relationship _____ Phone # _____

## Employer Information (Or parent/guardian employer information)

Name _____ Phone # _____

Address _____

City _____ State _____ Zip _____

## Problem

Problem Description _____ Date of Injury _____ Last Physician Visit _____

Referred by _____

Notes/Comments _____

**HIPAA Consent**

I have been given the right to review such Notice of Privacy practices prior to signing this consent. 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 to obtain a current copy of the notice.

I understand that I may revoke this consent in writing at any time except to the extent that Teton Therapy has taken action relying on this consent. **Please initial:** _____

**Attendance Policy**

It is expected that you keep all of your appointments. **If you need to reschedule an appointment, we require a 24 hour advance notice.** In such a case, please call our office to make arrangements for a make-up appointment. **In an instance of a same day cancellation, or a no show to a scheduled appointment, we will charge a $20 fee.**

In instances of repeated noncompliance with your scheduled visits, we also reserve the right to discontinue care. We will inform your physician that your services have been discontinued due to noncompliance with prescribed rehabilitation orders. **Please initial:** _____

**I do hereby agree and give my consent for Teton Therapy to furnish medical care and treatment considered necessary and proper in diagnosing or treating my/his/her physical condition. Please initial:** _____

**How did you hear about us?**

**Doctor** **Newsletter** **Radio** **Friend** **County 10** **Website** **Facebook**

**Other**_____

**Signature**: _____ **Date:** _____

## MEDICAL HISTORY

Patient Name _____ Patient Case/Condition _____
Referring Physician _____ Primary Physician _____

Date of injury /Onset Date _____

Have you had surgery for this injury? ○ Yes No ○ If yes, When _____
Type of Surgery _____

Are you currently taking any prescription or non-prescription medications: ○ Yes No ○ If yes please list:

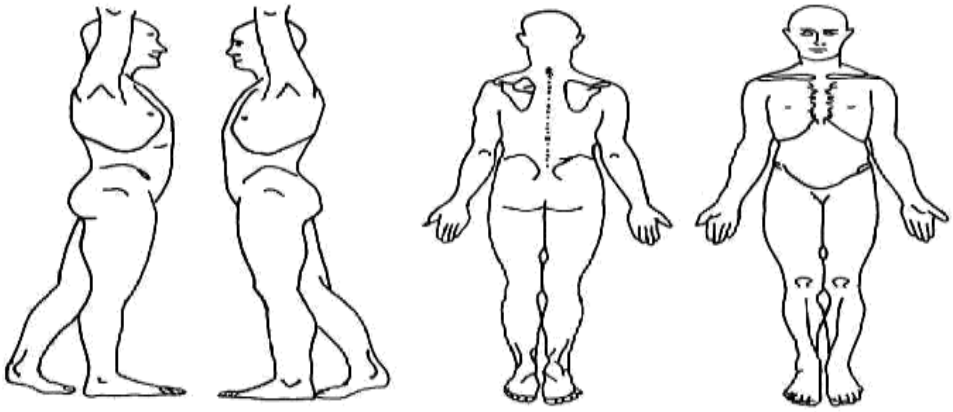
_____

_____

**Do you have or have you ever had any of the following?**

| | | | |
|---|---|---|---|
| Asthma, Emphysema | ○ Y N ○ | Severe or Frequent Headaches | ○ Y N ○ |
| Shortness of Breath/Chest Pain | ○ Y N ○ | Vision or Hearing Difficulties | ○ Y N ○ |
| Coronary Heart Disease | ○ Y N ○ | Numbness or Tingling | ○ Y N ○ |
| Pacemaker | ○ Y N ○ | Dizziness or fainting | ○ Y N ○ |
| Heart Attack/Surgery | ○ Y N ○ | Bowel or Bladder problems | ○ Y N ○ |
| Stroke/TIA | ○ Y N ○ | Weakness | ○ Y N ○ |
| Congestive Heart Disease | ○ Y N ○ | Weight Loss/Energy Loss | ○ Y N ○ |
| Blood Clot | ○ Y N ○ | Hernia | ○ Y N ○ |
| Epilepsy/Seizures | ○ Y N ○ | Varicose Veins | ○ Y N ○ |
| Thyroid Disease | ○ Y N ○ | Allergies | ○ Y N ○ |
| Anemia | ○ Y N ○ | Any pins or metal implants | ○ Y N ○ |
| Infectious Disease | ○ Y N ○ | Joint Replacement Surgery | ○ Y N ○ |
| Diabetes | ○ Y N ○ | Neck Injury/Surgery | ○ Y N ○ |
| Cancer/Chemotherapy/Radiation | ○ Y N ○ | Shoulder/Elbow/Hand Injury/Surgery | ○ Y N ○ |
| Arthritis | ○ Y N ○ | Back Injury/Surgery | ○ Y N ○ |
| Osteoporosis | ○ Y N ○ | Knee Injury/Surgery | ○ Y N ○ |
| Gout | ○ Y N ○ | Leg/Ankle/Foot Injury/Surgery | ○ Y N ○ |
| Sleeping Problems/Difficulties | ○ Y N ○ | Are You Pregnant? | ○ Y N ○ |
| Emotional/Psychological problems | ○ Y N ○ | Do you Smoke? | ○ Y N ○ |

**Mark on the picture where you are having your symptoms**, please be specific: X for pain, O for numbness, B for burning



**Signature**: _____ **Date:** _____

**FINANCIAL POLICY/ASSIGNMENT OF INSURANCE BENEFITS**

Our office staff will call and verify all insurance coverage that you may have, and contact you to provide an estimate of what each visit will cost. This amount is an estimate and the actual amount due may differ. You are responsible for any difference in what was quoted by your insurance company and what was actually paid. We recommend that you call your insurance carrier to gain understanding of your benefits. We will do everything in our power to ensure that we have the necessary referrals or authorizations, however it is ultimately your responsibility to verify that all visits are covered by a referral or authorization. Any charges incurred that are not covered by your insurance become your responsibility.

I do hereby authorize my insurance carriers to pay directly to Teton Therapy the insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for any charges transferred to me by my insurance carrier(s), including: co-pay, deductible and co-insurance amounts as well as those not covered by my insurance. I agree to pay all attorney fees, court costs, filing fees including commissions that may be assessed to me by any collection agency retained to pursue such matters. Payment of estimated charges are due at the time of service unless other arrangements are made.

**Responsible Party**

Name _____ SSN _____ DOB _____

Phone Number If Different _____ Address If Different _____

**Primary Insurance**

Company _____ ID# _____ Group # _____

Subscriber Name _____ Subscriber DOB _____ Relationship _____

If Medicare: Have you been on Home Health Services (•) Yes ( ) No Discharge Date _____

**Secondary Insurance**

Company _____ ID# _____ Group # _____

Subscriber Name _____ Subscriber DOB _____ Relationship _____

If Medicare: Have you been on Home Health Services ( ) Yes (•) No Discharge Date _____

****Must Provide Card for a Copy****

**If Workers Compensation or Auto Insurance, patients still need to provide us with their Private Insurance Information

**Workers Compensation**

Paying Agency/Sate _____ Case # _____

Case Manager _____ Phone#

Date of Accident _____ Employer at the Time of Injury _____

Supervisor Employer Phone # _____

Employer Address _____ Employer City, State, Zip _____

**Auto Insurance**

Insurance Company _____ Address _____

Claim # _____ Date of Accident _____

**Signature**: _____ **Date:** _____