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:** _____

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

How did you hear about us? Please circle any that apply.

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

Other_____

Signature: _____ **Date:** _____

FINANCIAL POLICY/ASSIGNMENT OF INSURANCE BENEFITS

Our office staff will call and verify all insurance coverage 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 you call your insurance carrier to gain understanding of your benefits. We will do everything in our power to ensure we have the necessary referrals or authorizations; however, it is ultimately your responsibility to verify 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 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:** _____

Missed Visit Policy

At Teton Therapy, our goal is to help all patients reach a fully recovered state. Your physical therapist will provide you with your plan for care during the evaluation appointment and will inform you of the required number of visits to help you achieve your goals. Patients who attend all of their physical therapy visits are 93% more likely to fully recover from an injury whereas those that miss even one visit have a lower potential for recovery. We are happy to share a copy of this study with you but want to make sure that you understand that it is extremely important that you attend all of appointments. This policy ensures that all patients have the opportunity to receive the care they need.

Please read our policy and sign at the bottom indicating you understand our expectations and our policy.

1. As experts, we know that **you will not reach full recovery if you do not attend your appointments**. To help ensure you have the best chance at recovery, we will work with you to schedule out all of your appointments after your evaluation today and in order to have the best chance at recovery, you will need to attend each visit.
2. Please note: Our goal is to begin your treatment sessions on schedule. For all appointments after your evaluation, we expect that you will arrive at least 5 minutes prior to your appointment time, dressed for your session, and ready to begin at on time. This will allow our front office to handle their responsibilities and our specialists to provide the care you need and deserve.
3. If you're late for your appointment, you're missing the time that we have specifically scheduled for your care and we cannot guarantee that we will be able to provide you with your full treatment as we have reserved the appointment time following yours for someone else.
4. If you're running late, we need you to call us immediately so we can prepare for your late arrival and consult with your clinician. If you are more than 15 minutes late, your session may need to be rescheduled and if that occurs, you will incur a missed visit charge. Chronically late patients will be asked to change their appointment times.
5. Our schedule is very full and certain time slots are not always available for patients who need them. If you need to cancel or change a scheduled appointment, for any reason, we require a day's notice **during business hours, so we have enough time to help someone else who needs an appointment time.**
6. When you call to cancel an appointment, have your schedule ready as we will reschedule you right away.
7. Same-day cancellations and appointment no-shows are not permitted as they keep other patients from getting the care they need.
8. There is a **$20 if you do not provide at least a days' notice of your appointment change or cancellation. This is non-negotiable and it's your responsibility as insurance will not cover it.**
9. While we understand that illness can strike at any time, we still expect that you will work to provide at least a day's notice if you cannot attend a scheduled appointment.
10. **To avoid our missed visit fee, call our office during business hours - at least ONE DAY in advance for any illness, appointment changes or cancellations.**
11. Patients who have multiple same-day cancellations or no-shows, will be removed from the schedule. We will also notify your physician of your non-compliance.
12. If you're worker's comp, we are required to notify your claims adjuster if you cancel or no-show.

We look forward to working with you to meet your physical therapy goals.

I have read this policy and by signing below I am indicating that I understand and this policy.

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:

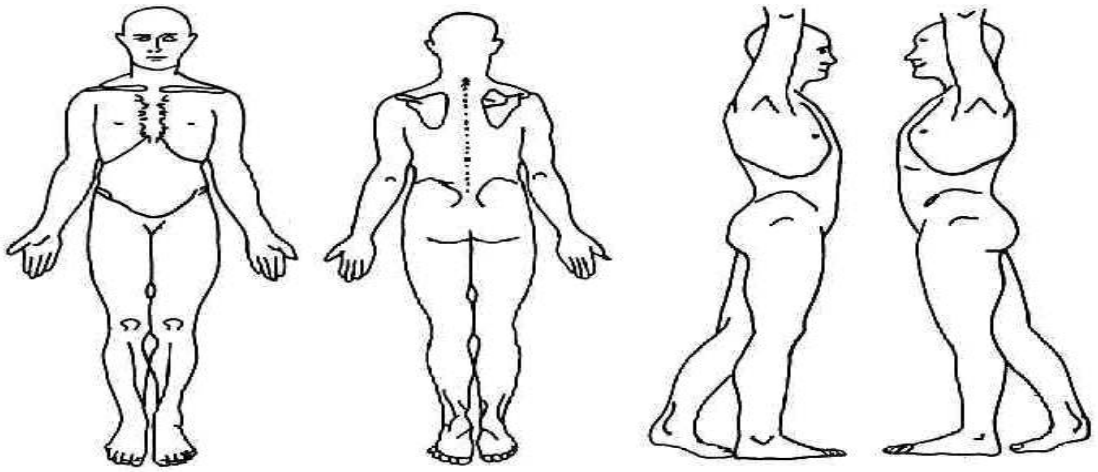
_____

_____

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

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

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



Signature: _____ **Date:** _____