ARKANSAS VALLEY PHYSICAL THERAPY
HEALING BODIES IN MOTION

Arkansas Valley Physical Therapy
New Patient Packet

DEMOGRAPHICS

Patient Information

First Name: MI: Last Name: Sex: M F

Address: City: State: Zip:

Home Phone: Work Phone: Cell Phone:

*Email SSN#: Date of Birth:

*By providing my email address I understand and agree to allow Arkansas Valley PT and it's employees to contact me via unencrypted email.

Referring Physician: Primary Care Physician:

Employer Name: Occupation:

Primary Insurance Subscriber Information

Insurance Carrier: Member ID: Group No:

First Name: MI: Last Name: Sex: M F DOB:

Address: City: State: Zip:

Relationship to Patient: Employer: SSN:

Secondary Insurance Subscriber Information (if applicable)

Insurance Carrier: Member ID: Group No:

First Name: MI: Last Name: Sex: M F DOB:

Address: City: State: Zip:

Relationship to Patient: Employer: SSN:

Guarantor/Guardian (If patient is a minor)

First Name: MI: Last Name: Sex:

Address: City: State: Zip:

Home Phone: Work Phone: Cell Phone:

SSN: Date of Birth: Email:

Employer Name: Patient's Relationship to Responsible Party:

Emergency Contact

First Name: Last Name: Relationship to Patient:

Home Phone: Cell Phone: Work Phone:

Communication Consent

" **Option A:** I give **Arkansas Valley PT** permission to leave detailed phone messages regarding my medical and/or billing information on:

Home# _____ " Medical " Billing

Cell# _____ " Medical " Billing

Work# _____ " Medical " Billing

I also authorize to release "medical and/or "billing information to: _____

" **Option B:** I wish to be contacted personally and do not authorize **Arkansas Valley PT** to leave detailed messages or discuss my care or billing account with anyone other than myself.

Patient or Responsible Party: **Date:**

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SYMPTOM DETAILS

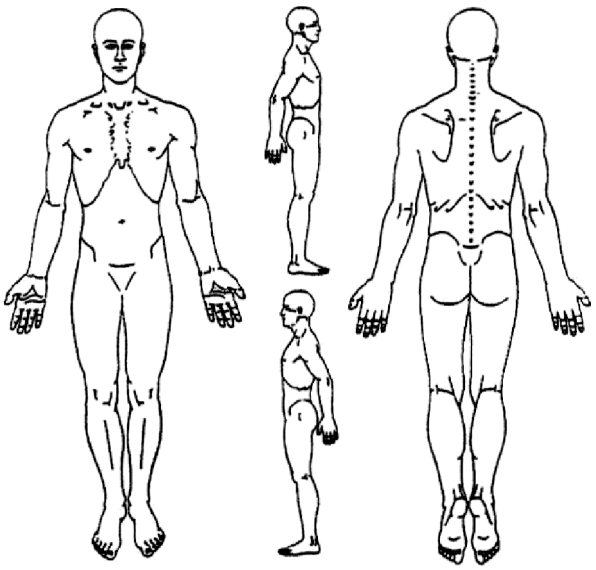
Patient Name:_____

Diagnosis (If you know or have been told):_____

_____

_____

Body part affected? (please indicate below)



Shoulder Elbow Wrist Neck Mid-back Low-back

Hip Knee Ankle Other:_____

Which side(s)? O Right O Left O Both

Dominant arm? O Right O Left

Problem(s) (please check all that apply)

O Pain

O Weakness

O Instability/Giving way/Dislocation

O Stiffness

O Swelling

O Other_____

How severe is your pain? (0-none & 10=severe)

At rest?	0	1	2	3	4	5	6	7	8	9	10
When active?	0	1	2	3	4	5	6	7	8	9	10
At Its worst?	0	1	2	s	4	s	g	7	8		10
At its best?	0	1	2	3	4	5	6	7	8	6	10

Do you have pain at night? OYES ONO

Does the pain awaken you from sleep? OYES ONO

Have you ever been seen for this issue by any other provider (le. chiropractor, physician)? OYES ONO

Last year, did you receive **any** of the following treatment (related or unrelated to today's visit):

0 None

0 Physical Therapy _____# visits
Services rendered at:_____

0 Occupational Therapy _____# visits
Services rendered at:_____

0 Chiropractic _____# visits

0 Speech Therapy _____# visits

0 Home Health _____# visits

Were you discharged from home health? OYES ONO

Have you received any injections? OYES ONO

Are you post surgical? OYES ONO

Date of Surgery: _____

_____

Type of Surgery: _____

List any additional surgeries you've received for this problem:_____

_____

Other unrelated surgeries: _____

_____

_____

This Is a result of... (mark all that apply)

0 No injury -just started hurting

Date of Onset_____

0 Sports Injury (which sport?) _____

0 Motor Vehicle Related

Do you have an open/payable claim Y N

0 Work/Job Related

Do you have an open/payable claim Y N

0 3rd Party Accident (involving insurance other than your own)

Injury : O Current O Old (greater than 1 year)

Date of Injury:_____

Please briefly describe how your injury happened:

_____

_____

_____

_____

(Patient Signature) (Date)

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MEDICAL HISTORY

A complete medical history is necessary for a thorough evaluation. Please answer the following questions:

Your Name:				Date:	
Data of Birth:	Age:	Height:	Weight:	Do you Smoke?:	**No Yes**

Have you ever been diagnosed with any of the following?

Tuberculosis	No	Yes	Fainting/Falls/Dizziness	No	Yes
Hepatitis	No	Yes	HIV/AIDs	No	Yes
Diabetes/Neuropathy	No	Yes	Bowel/Bladder Problems	No	Yes
Stroke	No	Yes	Blood Clots	No	Yes
Chronic Respiratory Problems	No	Y6S	Headaches/Migraines	No	Yes
Epilepsy/Seizures	No	Yes	High1ow Blood Pressure	No	Yes
Arthritis	NO	Yes	Pacemaker	NO	Yes
Cancer	No	Yas	Arrhythmia	No	Yes
Osteoporosis / Osteopenia	No	Yes	Congestive Heart Failure(CHF)	No	Yes
Closed Head Injury/TBI	No	Yes	Angina	No	Yes
Are you currently pregnant?	No	Yes	Other Heart Problems	No	Yes

Are you exercising? No Yes Describe: _____

Problems with exercise? No Yes Describe: _____

What do you hope to accomplish with therapy? _____

List all medications you currently take or ask us to copy your list

Medications	Diagnosis	Prescribing Physician

Is there any other pertinent information you would like us to know about your condition?

_____

_____

Patient or Responsible Party: _____ Date: _____

OFFICE USE- RTNP VERIFICATION:	
Initials	Date

ARKANSAS VALLEY PHYSICAL THERAPY
HEALING BODIES IN MOTION

245 East US-50 Suite 9
Salida, CO 81201
(719) 539-3626

1. Authorization for Release of Information — The HIPAA Privacy Rules allows those doctors, nurses, hospitals, laboratory technicians, and other healthcare providers that are covered entities to use or disclose protected health information, such as x-rays, laboratory and pathology reports, diagnoses, and other medical information for treatment purposes with the patient's authorization. This includes sharing the information to consult with other providers, including providers who are not covered entities, to treat a different patient, or to refer the patient.

2. Authorization for Treatment — I understand that therapy evaluations and treatment may potentially cause or aggravate symptoms and give my consent for the therapist to perform treatment as he/she deem necessary.

3. **Verification of Benefits** - I understand that Arkansas Valley Physical Therapy will attempt to obtain benefits from my insurance company, however, they will not be responsible for unauthorized services as well as any discrepancies between quoted benefits and actual benefits paid. I understand I am responsible for payment of services not covered by my insurance. I also understand and agree that I am responsible for verifying my own insurance benefits as well as knowing and understanding my plan limitation, maximum benefits available, deductible, coinsurance, and copayments. Because my insurance is a contract between myself and my insurance company, I understand that I must direct questions or concerns regarding payment of benefits to them.

4. **Financial Agreement** — I understand there is no guarantee of reimbursement or payment from any insurance company or other payor. I acknowledge full financial responsibility for and agree to pay all charges of the clinic and of therapist rendering services as allowable per the contractual terms between my insurance and Arkansas Valley Physical Therapy. All charges are due and payable upon receipt of the bill. If payment is not made within 30 days of the receipt of the bill a delinquent charge or interest at the maximum legal rate may be added. I agree to pay all reasonable legal expenses necessary for the collection of any debt.

5. **Assignment** for **Direct Payment** - I authorize and instruct my insurance carrier to make payment of medical benefits to Arkansas Valley Physical Therapy for therapy services rendered and that no payment be made payable to myself/insured party. If payment is made directly to myself/insured, I understand that I will be responsible for balance due.

6. **Cancellation/No Show Policy —** Our goal is to achieve optimal outcomes with you while you are receiving rehabilitation. You are a very important member of our rehabilitation team. I agree that if I am unable to attend my appointment, it is my responsibility to call at least 24 hours in advance or be subject to a $35.00 fee. If I fail to keep three appointments I could be dismissed from therapy and required to return to my physician to obtain a new prescription before resuming treatment.

7. I have read the Notice of Privacy Practices and have been offered a copy for my records. I am aware the Notice may be changed at any time. I was given the opportunity to review the Notice and ask questions regarding my privacy rights.

I ACKNOWLEDGE I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS. I FURTHER ACKNOWLEDGE THAT I AM THE PATIENT, OR PERSON DULY AUTHORIZED EITHER BY THE PATIENT OR OTHERWISE, TO SIGN THIS AGREEMENT, CONSENT TO, AND ACCEPT ITS TERMS

_____ _____

Patient/Responsible Party **Date**

OFFICE UGE- RTNP VERIFICATION:
Initials Date

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. (Note that your account must be paid in full to cancel). This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I,_____, authorize **ARKANSAS VALLEY PHYSICAL THERAPY** to charge my credit card above for agreed upon services. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date

ARKANSAS VALLEY PHYSICAL THERAPY
HEALING BODIES IN MOTION

Cancellation, and No-Show Policy
Effective January 1st, 2023

Arkansas Valley PT requires 24 hours' notice to cancel or reschedule your appointment.

We understand life happens and you may need to miss a scheduled appointment. However, please be considerate and provide adequate notice if you cannot make it. When you late cancel, we are unable to give that appointment to someone else who needs our assistance.

Patients who late cancel or no show will be charged a fee for the missed appointment. Physical therapists are paid by insurance for time spent treating patients, insurance does not pay for missed appointments or late arrivals. (We will make exceptions for bad weather, road conditions or if you are sick).

Fees

If you fail to provide **AT LEAST 24hr Notice**, the fee will be collected at your next appointment or charged to your credit card on file. If no visit is scheduled, a bill will be mailed to you.

Late Cancellations— $25 first incident; $50 for subsequent Incidents
No shows — $50 first incident, $75 for subsequent incidents
No Show for Initial visit — $85 per incident
**An initial visit will* NOT be *rescheduled until fee is paid*

Descriptions

Late Cancellation- Appointment is cancelled within 24 hours of scheduled appointment.
No Show- Patient cancels within 2 hours of appointment or does not show up for scheduled appointment.
Late Arrival- Patient arrives more than 15 minutes late.

Attendance Policy

Your success in physical therapy depends on your attendance and accountability. If you miss too many appointments or continually show up late, you will be removed from the therapy schedule until you are able to commit to the treatment process.

Reasons for removal from the schedule include:

- Excessive late cancellations
- No shows (after 2nd incident)
- Repeated late arrivals (more than 5 minutes late)

Cancelling? Please call the office at least 24 hours in advance (Monday appts need to *be cancelled by Friday, unless due to illness).*

Phone: 719-539-3626