ARGONAUT PEAK PHYSICAL THERAPY

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PATIENT INFORMATION

LAST NAME:____________________________ FIRST NAME:___________________________ MI:_____NICK NAME:___________________

BILLING ADDRESS:____CITY:______________________STATE:_____ ZIP CODE: ____________

DATE OF BIRTH:___________________________ ☐ Male ☐ Female

HOME PHONE:_________________________ CELL PHONE:______________________ WORK PHONE: ___________________________

EMAIL ADDRESS:_________________________________ Appointment reminders? ☐ Text ☐ Email ☐ Voice call

Your email address will be used only to send you Argonaut information. We will never share or sell your email address.

HOW DID YOU HEAR ABOUT US? ☐ Media ☐ Doctor ☐ Internet ☐ Insurance ☐ Family/Friend ☐ Previous Patient ☐ Other

HAVE YOU HAD PHYSICAL, MASSAGE, CHIROPRACTIC, OCCUPATIONAL, OR SPEECH THERAPY THIS YEAR: ☐ Yes ☐ No

AUTHORIZED ACCESS:

MAY WE CONTACT YOU AT WORK? ☐ YES ☐ NO

CAN DETAILED MESSAGES BE LEFT ON YOUR HOME OR CELL VOICE MAIL OR ANYONE WHO ANSWERS? ☐ YES ☐ NO

EMERGENCY CONTACT:____________________________ RELATIONSHIP:______________________ PHONE:__________________

EMPLOYMENT INFORMATION (L&I CASES ONLY):

OCCUPATION: _______________________________________ ☐ Student ☐ Retired ☐ Unemployed

EMPLOYER NAME:____ PHONE:______________________________

EMPLOYER ADDRESS:___________________________ CITY:________________________ STATE:________ZIP CODE:_________

*** **OFFICE USE ONLY** ***

INSURANCE/ID# (Primary): ____

Name of Payer/Guarantor: ________________________________ Payer/Guarantor Date of Birth: _________________

Copay/Coinsurance: _________ Deductible: __________________ Out of pocket: _____________________ Visits allowed: _________

INSURANCE/ID# (Secondary): ____

Copay/Coinsurance: _________ Deductible: __________________ Out of pocket: _____________________ Visits allowed: _________

REFERRING PHYSICIAN:____ PHONE:_______________________________________

PRIMARY CARE PHYSICIAN:____ PHONE:_______________________________________

DIAGNOSIS/ICD-10 CODE(S):

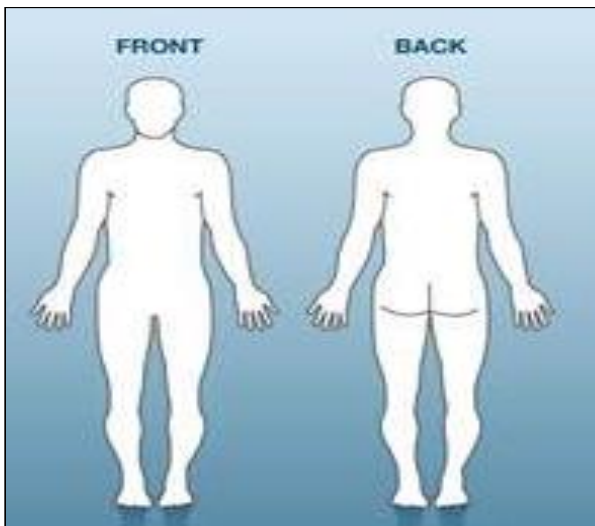

DIAGRAM WHERE YOUR DISCOMFORT IS ON THE IMAGES BELOW.

DULL ACHE: ///   NUMBNESS: 000
STABBING: +++   PINS & NEEDLES: XXX

RANK YOUR PAIN BELOW, 0 - 10 (0 IS NO PAIN, 10 IS UNBEARABLE):

AT IT'S BEST: 0 1 2 3 4 5 6 7 8 9 10

AT IT'S WORSE: 0 1 2 3 4 5 6 7 8 9 10

CURRENT: 0 1 2 3 4 5 6 7 8 9 10

CURRENT SYMPTOMS:

Primary Concern/Chief Complaint:____

When did this first begin? _______/________/_________

Have you had surgery for this problem? ☐ YES ☐ NO DATE: ____/_____/_____

How did this problem begin? ____

How often do you experience your symptoms? (Check below)

- ☐ Intermittently (0%-25% of the day)
- ☐ Occasionally (26%-50% of the day)
- ☐ Frequently (51%-75% of the day)
- ☐ Constantly (76%-100% of the day)

What makes your pain worse?____

What makes it better? ____

PAST MEDICAL HISTORY:

DO YOU SMOKE: ☐ Yes ☐ No   PREGNANT: ☐ Yes ☐ No   LATEX ALLERGY: ☐ Yes ☐ No

DO YOU OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY)

- ☐ Anxiety
- ☐ Autoimmune Diseases
- ☐ Cancer
- ☐ Cardiovascular Disease
- ☐ Circulation Disorders
- ☐ Diabetes, Type 1
- ☐ Diabetes, Type 2
- ☐ Fibromyalgia
- ☐ GI Disorders
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Kidney / Bladder Disorders
- ☐ Multiple Sclerosis
- ☐ Numbness or Tingling
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Parkinson's
- ☐ Rheumatoid arthritis
- ☐ Stroke
- ☐ Thrombosis (blood clots)
- ☐ Traumatic Brain Injury
- ☐ Other ________________________

ALLERGIES: ____

PAST SURGICAL PROCEDURE:___________________________ DATE:_________________ (EXACT / ESTIMATED)

PAST SURGICAL PROCEDURE:___________________________ DATE:_________________ (EXACT / ESTIMATED)

LIST CURRENT MEDICATIONS OR PROVIDE YOUR LIST: ____

Consent to Treat
I ____ hereby give my consent to Argonaut Peak Physical Therapy to perform reasonable and necessary medical examinations, testing and treatment. By initialing, you intend that this consent is continuing in nature throughout your treatment duration.

Responsible Party Initials _______

Payment / Co-pays
Co-pays are due at time of service. We will do our best to track your insurance benefit limits, however, it is ultimately the patient's responsibility to know their own benefit limits and / or maximums allowed on their insurance coverage. I agree to be responsible for any portion of my bill not covered by insurance. I understand and accept the responsibility of checking on my insurance benefits and complying with those requirements. Third party auto insurance cases are the patient's responsibility. A non-negotiable **$25.00 charge** will be assessed per returned check. Our bank charges a fee for all returned checks which will be passed onto you.

Responsible Party Initials _______

Appointments / Cancellation Policy
Please provide us with **24 hours**' notice if you will not be able to attend your scheduled appointment. We will take into account unforeseen emergencies. **Any patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours' notice will be considered a No Show and charged a $25.00 fee.** Any established patient who fails to show or cancels/reschedules an appointment with no 24 hour notice **a second time will be charged a $40.00 fee.** If a third No Show or cancellation/reschedule with no 24 hour notice should occur the patient may be discharged from care with Argonaut Peak Physical Therapy. In addition, the referring physician and case manager (if applicable) will be notified.

Responsible Party Initials _______

Privacy Practices
This office complies with national privacy standards to protect personal health information as required by HIPAA. Copies of these policies are available upon request and are posted in the office.

Responsible Party Initials _______

Insurance Assignment and Release of Payment to Therapist:
I hereby authorize payment directly to Argonaut Peak Physical Therapy for all insurance benefits, including private insurance, workers compensation and motor vehicle insurance, otherwise payable to me for medical services rendered. I understand that this authorization of payment to my provider is an irrevocable agreement. I authorize my provider to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I have read, understand and agree to the above.

Responsible Party Initials _______

Medicare-Authorization and Release of Payment to Therapist:

I request that payment of authorized MEDICARE benefits to be made to my attending provider, for any services furnished to me by the provider. I agree to be held personally responsible for services provided to me that are not authorized by MEDICARE. I authorize any holder of medical information about me to release to the HEALTH CARE FINANCING ADMINISTRATION, aka CMS and its agents any information to determine these benefits of the benefits payable for related services.

Responsible Party Initials _______ *(Only for Medicare patients)*

I ____(please print name) have read and understand the above mentioned policies. My signature is my agreement to all mentioned policies with Argonaut Peak Physical Therapy.

____ __________________________
Responsible Party Signature **Date**