ARGONAUT PEAK PHYSICAL THERAPY

JONATHAN SUTTLES, MS PT ANDREA TIERNEY, DPT, MS ATC

PATIENT INFORMATION

LAST NAME:_____ FIRST NAME:_____ MI:_____NICK NAME:_____

BILLING

ADDRESS:_____CITY:_____STATE:_____ZIP CODE: _____

HOME

ADDRESS:_____CITY:_____STATE: _____ZIP CODE:_____

EMAIL ADDRESS:_____

DATE OF BIRTH:_____SS# *(Optional)*_____

□ MALE □ FEMALE MARTIAL STATUS: □ SINGLE □ MARRIED □ DIVORCED □ WIDOWED

HOME PHONE:_____ WORK PHONE:_____ CELL PHONE:_____

PARENT(S) NAME:_____PHONE:_____

INSURANCE/ID# (Primary): _____

INSURANCE/ID# (Secondary): _____

REFERRING PHYSICIAN:_____ PHONE:_____

PRIMARY CARE PHSYSICIAN:_____ PHONE:_____

DIAGNOSIS/ICD-10 CODE(S):

STUDENT: □ YES □ NO

OCCUPATION:_____ □ UNEMPLOYED □ RETIRED □ LAID OFF

EMPLOYER (Required):_____ PHONE:_____

EMPLOYER ADDRESS:_____ CITY:_____ STATE:_____ZIP CODE:_____

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:_____

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Patient Medical History

PATIENT NAME:_____ DATE:_____

HOW DID YOU HEAR ABOUT ARGONAUT PEAK PHYSICAL THERAPY: _____

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

DATE OF INJURY:_____DATE OF SURGERY:_____

CURRENT SYMPTOMS: _____

BRIEFLY DESCRIBE YOUR INJURY OR EVENTS LEADING TO YOUR SYMPTOMS: _____

_____

LIST ACTIVITIES THAT YOU CAN'T DO OR DO ONLY WITH SIGNIFICANT PAIN / DIFFICULTY:_____

_____

DO YOU SMOKE: □ Yes □ No

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

□ Acute Infection of any kind
□ Acute Bronchitis
□ Abdominal Surgery
□ Bronchial Asthma
□ Cardiac Disease
□ Crohn's Disease
□ Diabetes
□ Diverticulitis
□ Neurological Disorders (IE. Stroke, Seizures)
□ Congestive Heart Failure
□ Cancer
□ Osteoporosis
□ Kidney / Bladder Disorders
□ Circulation Disorders
□ Hyperthyroidism (overactive thyroid)
□ Hypothyroidism (underactive thyroid)
□ Hypertension
□ Latex Allergies
□ Paralysis
□ Pregnant
□ Thrombosis (blood clots)
□ Unexplained Pain
□ Heart Attack
□ High Blood Pressure
□ Gastrointestinal Disorders
□ Arthritis
□ Liver Disease
□ Other: _____

PAST SURGICAL PROCEDURE:_____ DATE:_____ (EXACT / ESTIMATED)

PAST SURGICAL PROCEDURE:_____ DATE:_____ (EXACT / ESTIMATED)

PAST SURGICAL PROCEDURE:_____ DATE:_____ (EXACT / ESTIMATED)

LIST CURRENT MEDICATIONS: (OR PROVIDE YOUR LIST) _____

_____

ALLERGIES:_____

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PAIN SCALE

PATIENT NAME:_____ DATE:_____

DIAGRAM WHERE YOUR DISCOMFORT IS ON THE IMAGES BELOW.

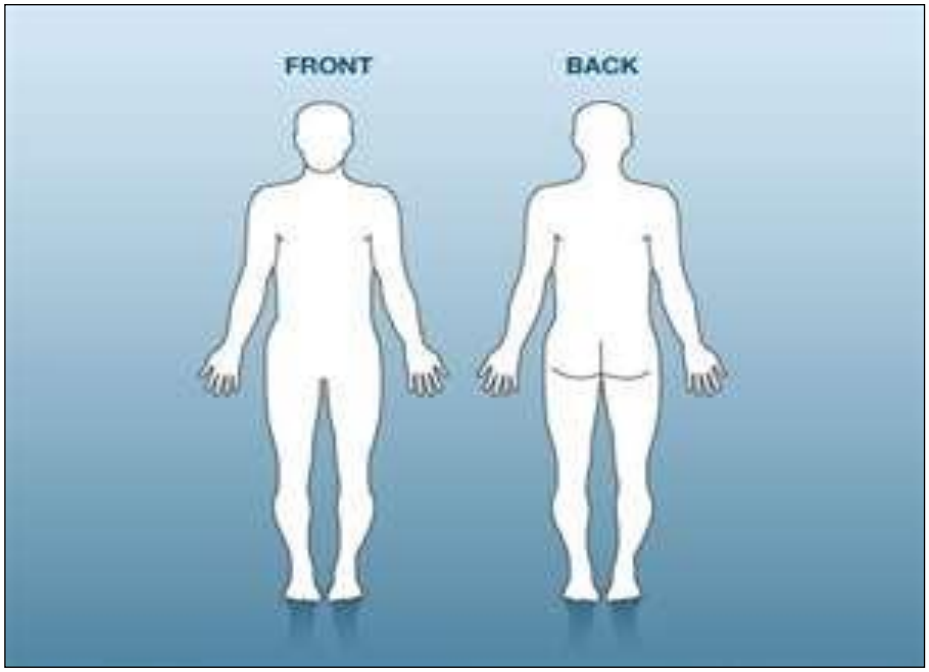
YOU MAY "X" WHERE YOU ARE HAVING SYMPTOMS **OR** USE THE SYMBOLS BELOW IF YOU FIND THEM HELPFUL.

DULL ACHE: ///

NUMBNESS: 000

STABBING: +++

PINS & NEEDLES: XXX



RATE YOUR DISCOMFORT ON A SCALE OF 0 TO 10 BY CIRCLING THE NUMBER THAT BEST DESCRIBES YOUR DISCOMFORT.

ZERO – NO PAIN		**THREE – MILD / NAGGING PAIN**			**FIVE – TROUBLESOME PAIN**				**TEN – UNBEARABLE PAIN**	
AT IT'S BEST:	0	1	2	3	4	5	6	7	8	9	10
AT IT'S WORST:	0	1	2	3	4	5	6	7	8	9	10
MOST OF THE TIME:	0	1	2	3	4	5	6	7	8	9	10

ARGONAUT PEAK PHYSICAL THERAPY

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We are pleased that you have chosen Argonaut Peak Physical Therapy for your rehabilitation needs. Our goal is to help restore your body to its optimum level of function.

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.

Appointments / Cancellation Policy

Appointment changes / cancellations - please provide us with **24 hours** notice if you will not be able to attend your scheduled appointment. **Failure to give adequate notice for cancellation will result in a $25.00 charge**. We will take into account unforeseen emergencies.

Return Check Policy

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.

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.

I _____ 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

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.

_____ _____

Signature of Responsible Party Date

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.

_____ _____

Signature of Responsible Party Date

MEDICAL APPOINTMENT CANCELATION/NO SHOW POLICY

Thank you for trusting your medical care to Argonaut Peak Physical Therapy. When you schedule an appointment with Argonaut Peak Physical Therapy, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, ***please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment***. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancelation/No Show Policy below:

- Effective February 19, 2018 any established 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.
- Any new patient who fails to show (without notice) for their initial visit will not be rescheduled and their referring physician will be notified.
- The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit or will be invoiced if the patient has been discharged.
- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect. We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee. You may contact Argonaut Peak Physical Therapy 24 hours a day, 7 days a week at the numbers below. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message. Messages left at either location are acceptable.

Ellensburg: 509-962-1553

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

_____ _____

Signature (parent/legal guardian) Relationship to patient

_____ _____

Printed Name Date