RANGE
PHYSICAL THERAPY + WELLNESS

PATIENT INFORMATION

Patient Name _____ DOB: _____ Date: _____
First M.I. Last

Email _____ Phone: _____

Address _____City_____ State_____ Zip:_____

Social Security #_____ Drivers License # _____

Occupation: _____ □Full time □Part Time □Retired □Other Employer: _____

Gender: □M □F □Prefer not to specify Marital Status: □Single □Married □Divorced □Widowed

Appointment reminders: □Email □Text □ none

Who may we thank for referring you? _____

RESPONSIBLE PARTY

□ Self (IF SELF, GO TO NEXT SECTION) □Parent □Spouse □Other (define)_____

Responsible Party's Name_____Date of Birth_____ Phone_____

Address_____City_____State____ Zip Code_____

Social Security #_____

Employer_____ Work Phone_____

ACCIDENT INFORMATION

Motor Vehicle Accident? □Yes □No Date of Accident _____

Adjustor_____ Claim #_____ Phone_____

Work Related Injury? □Yes □No Date of Accident _____

Adjustor_____ Claim #_____ Phone_____

Attorney Involved? □Yes □No Date of Accident _____

Adjustor_____ Claim #_____ Phone_____

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PRIVATE INSURANCE

Do you have Insurance? □Yes □No □see scanned card
If yes - Primary Insurance Name_____ Phone_____
ID#_____ Group #_____

If applicable:
Secondary Insurance Name_____ Phone_____
ID#_____ Group #_____

EMERGENCY / ALTERNATIVE CONTACT

Name_____ Phone _____ Relationship_____

ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION

I hereby authorize payment to Range Physical Therapy & Wellness PLLC for professional services rendered to me or my dependent and I shall be personally responsible for any unpaid balance due. I authorize the release of any medical information necessary to processes.

_____ _____ _____
Name Relationship Date

ACKNOWLEDGEMENT OF RESPONSIBILITIES

I, _____, acknowledge that Range Physical Therapy & Wellness PLLC may conduct a benefit and eligibility check prior to my initial visit. I will not hold Range Physical Therapy & Wellness, PLLC, nor any of its affiliates responsible for errors that may result from these checks. I acknowledge that insurance companies sometimes give inaccurate information, over the phone or online, and release Range Physical Therapy & Wellness, PLLC, and its affiliates, from any misinformation presented to me.

_____ _____
Signature of patient/guarantor Date

_____
Printed name of patient/guarantor

Ph: 406.370.1377
Fax: 406.258.0645
945 Wyoming St Suite 135
Missoula, MT 59801
info@rangeptmontana.com
www.rangePTmontana.com

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MEDICAL INFORMATION

Have you ever had any of the following? (Please check ALL that apply)

□Allergies
□Asthma / difficulty breathing
□Cancer
□Depression / Anxiety
□Diabetes or hypo/hyperglycemia
□Dizziness / Vertigo
□Fracture or Suspected Fracture
□Headaches / injury to head
□Heart condition / pacemaker
□High / low blood pressure
□Lung disorders
□Mental condition
□Multiple Sclerosis
□Night pain
□Osteoporosis
□ Osteoarthritis or Rheumatoid arthritis
□Parkinson's
□Stroke
□Swelling / joint pain
□Vision / hearing problems
□Surgeries: _____
□Other: _____

Use of tobacco? □Yes □No □In the past

Any recent unexplained weight loss? □Yes □No

Are you currently pregnant? □Yes □No

Falls in past year? □Yes □No How many: _____

CURRENT CONDITION

What are you being treated for? _____

When did it start?_____ How did it happen? _____

What makes it better? _____ What makes it worse? _____

Imaging: □MRI □X-Ray □Other Date / Office: _____

Previous or recent surgery for this issue (type, date): _____

Have you noticed in recent changes in: □Bowel/bladder □Weakness □Numbness

Any other pertinent information? _____

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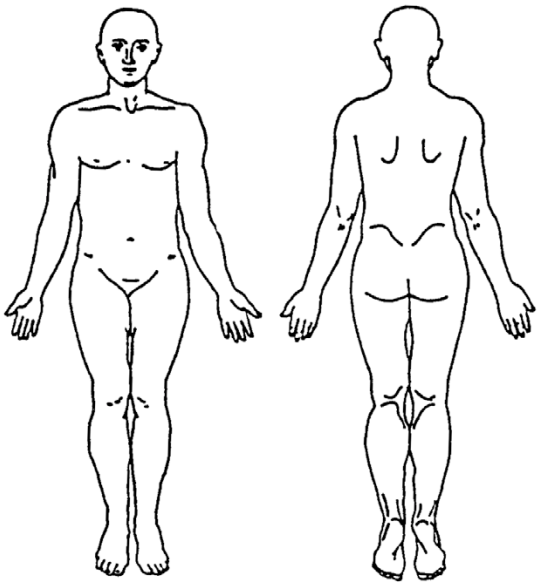
MEDICATION LIST

MEDICATION	DOSE / FREQUENCY	REASON

Please use the diagram below to indicate the symptoms you are experiencing.

A: ache S: stabbing R: radiating P: pins and needles N: numbness O: other



Please circle the severity of your pain, 0 (being no pain) 10 (being severe pain)

Current Level of Symptoms	0	1	2	3	4	5	6	7	8	9	10
Worst Level of Symptoms	0	1	2	3	4	5	6	7	8	9	10
Least Level of Symptoms	0	1	2	3	4	5	6	7	8	9	10

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PATIENT RESPONSIBILITY

We will bill your insurance as a courtesy for you. If your insurance requires pre-authorization, it is your responsibility to inform us. If notification was not given, you may be held responsible for the denied services. You will be responsible for the deductible and copays, and for knowing your insurance coverage caps. Copays and deductibles may be collected at the time of each service. If necessary, payment plans for charges not reimbursed by insurance can be arranged by our billing office.

Cancellation / No-Show Policy: If you are unable to keep your appointment **please provide a 24 hour advance notice,** otherwise a $50.00 late cancellation or no-show fee may be administered (which is not covered by insurance).

By signing below, I agree to the payment requirements outlined above and give Range Physical Therapy & Wellness permission to charge my current credit / debit card on file:

_____	_____	_____
Patient or Guardian, Printed Name	Signature	Date

If you have questions regarding claims, please contact our billing office at 530-255-4120.

HIPAA Acknowledgement

Patient Consent of Receiving "Notice of Privacy Practices"

I, _____ (printed name of patient), hereby acknowledge that I was offered a printed copy of the *Notice of Patient Privacy Practices* and consent to the provisions of this Privacy Notice.

I authorize release of protected health information as defined by HIPAA and allow for electronic/verbal/written communication without my physical presence between Range Physical Therapy & Wellness, PLLC and the following parties/individuals.

Referring Provider: _____

Other - Name: _____ Relationship _____

Other - Name: _____ Relationship _____

I hereby authorize Range Physical Therapy & Wellness, PLLC to release all information regarding my physical therapy to my health insurance, physician, attorney, or responsible party insurance carrier. I authorize treatment and agree to be responsible for all payments not covered by my insurance unless prior arrangements are made.

Signature _____ Date_____

(Patient, parent, or legal guardian)

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