



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

Emergency Contact / Alternative Contact: _____
 Name Phone Relationship

Appointment reminders: Email Text none Who may we thank for referring you? _____

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 # _____

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 _____



HIPAA Acknowledgement and Release of Information
Patient Consent of Receiving “Notice of Privacy Practices”
Acknowledgement of Responsibilities

I acknowledge that I was offered a printed copy of Range Physical Therapy & Wellness PLLC’s (“Range PT”) *Notice of Patient Privacy Practices* and consent to the provisions of this Privacy Notice. I authorize the release of protected health information as defined by Health Insurance Portability and Accountability Act (HIPAA) and allow for electronic/verbal/written communication without my physical presence between Range PT and the following parties/individuals.

Referring Provider / Physician: _____

Other - Name: _____ Relationship _____

Other - Name: _____ Relationship _____

I, hereby authorize Range PT to release all information regarding my physical therapy to my insurers, physicians, attorneys, or other insurance carriers. I authorize treatment and agree to be responsible for all payments not covered by my insurance. I authorize the release of any medical information necessary to proceed payments for professional services. I hereby authorize payment to Range Physical Therapy & Wellness PLLC for professional services. I hereby authorize payment to Range PT for professional services rendered to me or my dependent and I shall be personally responsible for any unpaid balance due.

I, hereby acknowledge that Range PT may conduct a benefit and eligibility check prior to my initial visit. I will not hold Range PT, nor any of its members, managers, employees, agents, or 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 PT, and members, managers, employees, agents, and affiliates, from any misinformation presented to me.

Range PT will bill your insurance as a courtesy for you. If your insurance requires pre-authorization for Range PT’s services, you must inform us in writing. If you do not provide Range PT written notification that Range PT’s services require your insurer’s pre-authorization before Range PT provides the service, then you should pay for Range PT’s services that were not pre-approved by your insurer. 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, and if agreed to in writing by Range PT, payment plans for charges not reimbursed by insurance can be made by our billing office.

Cancellation / No-Show Policy: If you are unable to keep your appointment, you must provide Range PT at least **24 hours’ advance written notice by emailing info@rangeptmontana.com**, 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 foregoing terms and conditions and authorize Range PT to charge my current credit / debit card on file.



Patient or Guarantor, Printed Name

Signature

Date



MEDICAL INFORMATION

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

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

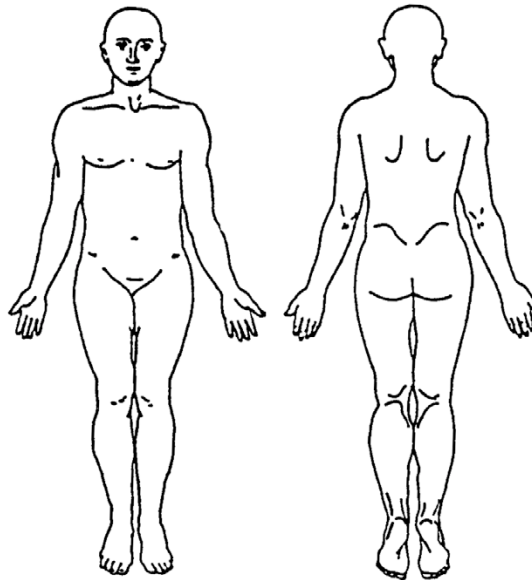
Any other pertinent information? _____

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