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

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_____

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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? _____

_____

MEDICATION LIST

Ph: 406.370.1377
Fax: 406.258.0645

1221 South Higgins Ave.
Missoula, MT 59801

info@rangeptmontana.com
www.rangePTmontana.com

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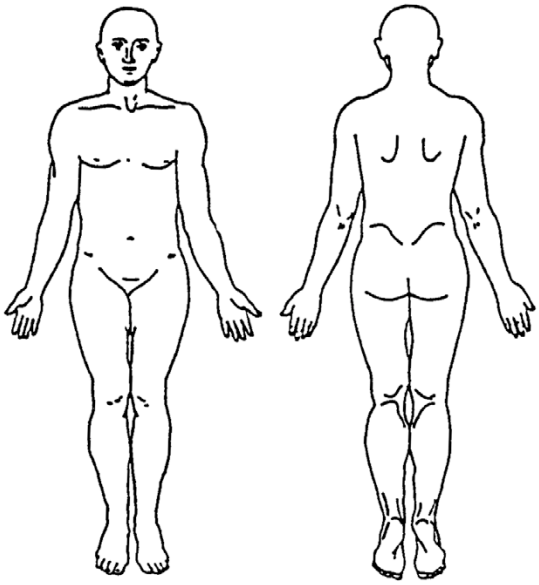
MEDICATION	DOSE / FREQUENCY	REASON

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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Payment / Card Policy:

Range Physical Therapy & Wellness requires a valid debit or credit card on file. Cards are securely stored through Jane Payments, a PCI DSS–compliant system. Staff cannot view your full card details. Range Physical Therapy & Wellness may keep this card on file and utilize this card to obtain payment for any and all charges you accrue on your account, including but not limited to: (1) fees for services provided; (2) late cancellation/no show fees; and (3) fees due at time of services (ie copays). To the extent this card ever becomes invalid, you agree to immediately provide Range PT with an updated and valid card. Your treatment may temporarily be suspended if you fail to maintain an active card on file at all times.
I agree to the above Payment Policy, authorizing Range Physical Therapy & Wellness to keep my card on file and to utilize it for payment of services rendered, payments due at time of service, and/or late cancellation/no show fees.

Initial Here:_____

Text Message Communication

I consent to receiving text messages from Range Physical Therapy & Wellness at the phone number provided for purposes such as appointment reminders, scheduling updates, and care-related information. I understand this list is not exhaustive. I also understand text messaging is not a secure form of communication, and confidentiality cannot be guaranteed. I acknowledge that message and data rates may apply, and I can opt out at any time by written notice to Range Physical Therapy & Wellness.

Initial Here:_____

Cancellation / No-Show Policy

If you are unable to attend your scheduled appointment, **you must provide Range PT at least 24 hours' advance written notice by emailing info@rangeptmontana.com or calling (406) 370-1377, otherwise a $50.00 late cancellation or no-show fee will be administered** for each occurrence and may be immediately charged to the card on file (which is not covered by insurance). You will not be able to attend future appointments until this fee is paid in full. If you late-cancel (less than 24 hours) or no show more than two times, you will be removed from the schedule. As identified herein after two occurrences, under Range's discretion, you may be asked to schedule only day-of appointments when available or discharged from our practice. We have an answering machine on 24-hours a day for you to leave a message.
By initialing below, I agree to the above-Cancellation Policy.

Initial Here:_____

Artificial Intelligence-Assisted Note-Taking

Range Physical Therapy & Wellness utilizes artificial intelligence assisted note taking during the course of its services. You have the right to opt-out of such artificial intelligence assisted note taking.
I consent and understand that artificial intelligence-assisted note-taking may be used during my visits. I understand that this involves temporary audio recording solely for documentation purposes, with no recordings stored. All data is processed on a HIPAA-compliant platform, ensuring my privacy and security. I acknowledge that my provider will review and sign off on the final note, ensuring consistency and accuracy in my care. This allows my provider to spend more focused time with me, enhancing the quality of my experience.

Initial Here:_____

By signing below, I agree to all of the terms and conditions and payment requirements outlined above:

X _____ _____ _____

Patient or Guarantor, Printed Name | Signature | Date

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