Missoula Physical Therapy

PATIENT INFORMATION

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

Email _____ Cell Phone: _____

Address _____City_____ State_____ Zip:_____

Social Security #_____ Drivers License # _____

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

Marital Status: □Single □Married □Divorced□Widowed Height:_____ Weight:_____

Appointment reminders: □Email □Text □ none Gender:_____ Age:_____

Referring Physician:_____

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_____

Ph: 406-544-2424
Fax: 833-544-0794

1502 Dearborn Ave, Suite B
Missoula, MT 59801

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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 number Relationship

ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION

I hereby authorize payment to Missoula Physical Therapy, LLC 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 Missoula Physical Therapy, LLC may conduct a benefit and eligibility check prior to my initial visit. I will not hold Missoula Physical Therapy, LLC, 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 Missoula Physical Therapy, LLC, and its affiliates, from any misinformation presented to me.

_____ _____
Signature of patient/guarantor Date

_____
Printed name of patient/guarantor

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MEDICAL INFORMATION

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

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

Use of tobacco? □Yes □No □In the past

Are you currently pregnant? □Yes □No

Unexplained weight loss? □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? _____

Pain Today (0-10)_____ Worst Pain Level(0-10)_____ Least Pain Level(0-100)_____

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? _____

Do you currently take any medication on a regular basis (please list)? _____

_____

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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).

Signing below, I agree to the payment requirements outlined above and give Missoula Physical Therapy, LLC 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 406-420-0203.

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 Missoula Physical Therapy, LLC and the following parties/individuals.

Referring Provider: _____

Other - Name: _____ Relationship _____

Other - Name: _____ Relationship _____

I hereby authorize Missoula Physical Therapy, LLC 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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