## **PATIENT INFORMATION**

Patient NameFirst		DOB:	Date:
First	M.I. Last		
Email	Cell Phone:		
Address	C	ity	State Zip:
Social Security #	D	rivers License	#
Occupation:	□Full time □Pa	rt Time □Retire	ed □Other
Marital Status: □Single □M	arried □Divorced□Wio	dowed Heigh	nt: Weight:
Appointment reminders:   —E	Email □Text □ none (	Gender:	Age:
Referring Physician:		_	
	RESPONSIB	I E DADTV	
	RESPONSIB	LE PARIT	
□ Self (IF SELF, GO TO NE	EXT SECTION) □Pare	nt □Spouse □	Other(define)
Responsible Party's Name_			Date of Birth
Phone	Address		
CityState	Zip Code	Social	Security #
Employer		Work P	hone
	ACCIDENT INI	FORMATION	
Motor Vehicle Accident?	∕es □No Date of Accid	lent	
Adjustor	Claim #		Phone
Work Related Injury? □Yes	□No Date of Accident	t	
Adjustor	Claim #		Phone
Attorney Involved? □Yes □	No Date of Accident _		_
Adjustor	Claim #		Phone

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



## PRIVATE INSURANCE

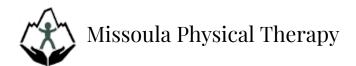
Do you have insurance? I fes I no	usee scanned card	
If yes		
Primary Insurance NameID#	Phon	e
ID#	Group #	
If applicable:		
Secondary Insurance NameID#	Phor	ıe
ID#	Group #	
EMERGE	ENCY / ALTERNATIVE CONTACT	
Name	Phone number	Relationship
ASSIGNMENT OF	BENEFITS / RELEASE OF INFOR	<u>MATION</u>
I hereby authorize payment to Misso rendered to me or my dependent an due. I authorize the release of any n	nd I shall be personally responsible f	for any unpaid balance
Name	Relationship	Date
ACKNOWLE	EDGEMENT OF RESPONSIBILITIE	<u>:S</u>
I,	s affiliates responsible for errors thace ce companies sometimes give inacc ssoula Physical Therapy, LLC, and i	will not hold Missoula at may result from these curate information, over
Signature of patient/guarantor		!
Printed name of patient/guarantor		

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## **MEDICAL INFORMATION**

□ Allergies	leck ALL that apply) □Dizziness / Vertigo			
□Mental condition	□Parkinson's			
□Asthma / difficulty breathing	□Fracture or Suspected Fracture			
□Multiple Sclerosis	□Stroke			
□Cancer	□Headaches / injury to head			
□Night pain	□Swelling / joint pain			
□Depression / Anxiety	□ Heart condition / pacemaker			
□Osteoporosis	□Vision / hearing problems			
□Diabetes or hypo/hyperglycemia	□High / low blood pressure			
□Osteoarthritis	□Surgeries:			
□Rheumatoid Arthritis	□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) Least Pain Level(0-100) 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).

(which is not covered by insurance).	
Signing below, I agree to the payment re Therapy, LLC permission to charge my	equirements outlined above and give Missoula Physical 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.
	AA Acknowledgement
Patient Consent of Receiving "Notice of (printed name of patient), hereby acknowledge	Privacy Practices" I,
Patient Privacy Practices and consent to	
•	
Other - Name:	Relationship
Other - Name:	Relationship
physical therapy to my health insurance	nerapy, LLC to release all information regarding my , physician, attorney, or responsible party insurance to be responsible for all payments not covered by my e made.
Signature	Date
(Patient, parent, or legal	guardian)

Ph: 406-544-2424 1502 Dearborn Ave, Suite B Fax: 833-544-0794 Missoula, MT 59801