Consent of Care and Treatment

I, the undersigned, do hereby agree and give my consent for *Rocky Mountain Spine and Sport Physical Therapy,* to provide medical care and treatment that is considered necessary and proper in diagnosing or treating my physical and mental condition.

Patient/Guardian: _____ Date: _____

Release of Information

I hereby authorize the said assignee to release and gather all information necessary, including Medical Records, Physician notes, radiological scans, operation report(s), to provide care and secure payment for any treatment received at *Rocky Mountain Spine and Sport Physical Therapy,* as required, until further notice.

Patient/Guardian*:* _____ Date: _____

Financial Policy Statement

***Rocky Mountain Spine and Sport Physical Therapy* will submit your claims to your insurance company, on your behalf. You are responsible for the entire bill once services are rendered. EOBs and invoices will come from Panorama Orthopedics and Spine (POSC). We may require that arrangements for payment of your estimated share be made prior to the rendering of services, depending on your insurance benefits. If your insurance does not remit payment within 60 days, the balance will be due from you. In the event that your insurance company establishes an internal usual and customary fee schedule, you will be responsible for the remaining difference.**

If payment is made directly to you for services billed by us, you recognize that you now have the obligation to promptly remit payment to *Rocky Mountain Spine and Sport Physical Therapy.*

The above does not apply for those patients that are considered Worker's Compensation. However, be advised that if your WC claim is denied such benefits, you may be held responsible for the total amount of charges for the services rendered to you.

I understand and agree that if I fail to make payments for which I am responsible in a timely manner, I will be responsible for all cost of collecting monies owed, including court costs, collection agency and attorney fees, plus interest thereon at 18% (eighteen percent) per annum on all such amount outstanding. Also, please be aware that there will be a *$25.00* service charge on all returned checks and additional charges for the cost of collection.

Estimated Insurance Benefits:

DED:	**OOP:**	**Visits/Cap:**
Met DED:	**Met OOP:**	**Visits/ Cap Used:**
CoIns: %	**Copay/ Collect towards DED: $**	**Prior Auth/Ref:**

Note: Estimated benefits coverage is provided as a courtesy to you, but is not intended to release you from total responsibility for your account.

***The above information has been read and explained to me. I understand my responsibility for the payment of my account.**

Patient/Guardian: _____ Date: _____

Medical History Intake

Family/Personal History

Patient Name:_____ DOB:_____ Age:_____
Employer:_____ Phone #:_____
Employer Address:_____
Emergency Contact/Relationship:_____ Phone #:_____
Family Physician:_____ Surgery: Yes / No If yes, date of surgery:_____
Are you currently taking any prescription or non-prescription medication: Yes / No
List all medication you are currently taking:_____
Are you allergic to: Medications Latex Adhesive
List all allergies:_____
Do you have a family history of: Cancer High Cholesterol Diabetes Heart Attack High Blood Pressure

Personal History

Do you have or ever had? Yes

Cancer:_____ ☐
Shortness of Breath ☐
Chest Pain (Angina) ☐
Night Sweats ☐
Pain that wakes you from sleep ☐
Weight Loss ☐
High Blood Pressure ☐
Coronary Artery Disease ☐
Heart Attack ☐
Blood Clot ☐
Stroke or TIA ☐
Do you have a pacemaker ☐
Irregular Heartbeat ☐
Anemia ☐
Ulcer/Stomach problems ☐
High Cholesterol ☐

Diabetes ☐
Vision/Hearing Problems ☐
Thyroid Disease ☐
Fatigue ☐
Depression ☐
Emotional/Psychological Dx ☐
Bowel/Bladder Problems ☐
Numbness/Tingling ☐
Joint Replacement ☐
Pins or Metal Implants ☐
Foot/Ankle Injury/Surgery ☐
Knee Injury/Surgery ☐
Neck Injury/Surgery ☐
Hepatitis ☐
Varicose Veins ☐

Shoulder Injury/Surgery ☐
Osteoporosis ☐
Osteopenia ☐
Epilepsy/Seizure ☐
Gout ☐
Weakness ☐
Do you smoke ☐
Are you pregnant ☐
Recently given birth ☐
Chemical dependency ☐
Eating disorder ☐
Anxiety/Panic attacks ☐
Asthma/Breathing problem ☐
Pneumonia ☐
HIV/AIDS ☐

Have you fallen in the past year?	Yes	No
Did you sustain an injury from the fall?	Yes	No
Have you had two or more falls in the past year?	Yes	No

Patient Signature:_____ Date_____

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

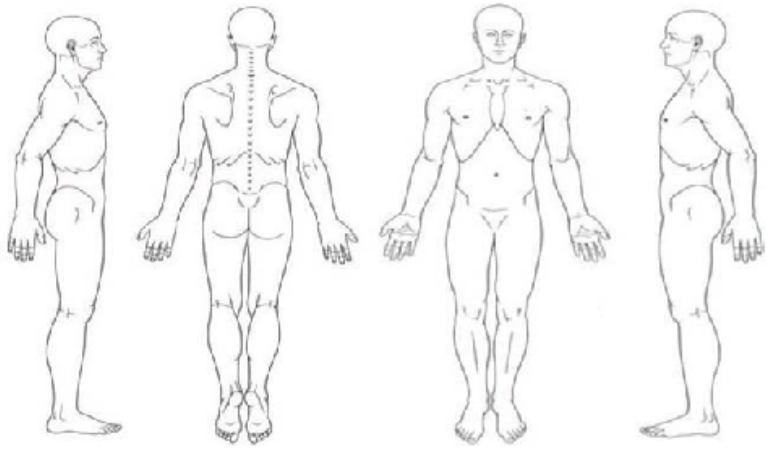
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⑩ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ *Unbearable*

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

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8. Who have you seen for your symptoms?

① No One ③ Medical Doctor ⑤ Other
② Chiropractor ④ Physical Therapist

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office ③ Medical Doctor ⑤ Other
② Chiropractor ④ Physical Therapist

10. What is your occupation?

① Professional/Executive ④ Laborer ⑦ Retired
② White Collar/Secretarial ⑤ Homemaker ⑧ Other
③ Tradesperson ⑥ FT Student

_____

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time ③ Self-employed ⑤ Off work
② Part-time ④ Unemployed ⑥ Other

Patient Signature _____ **Date** _____

Rocky Mountain Spine and Sport
Cancellation/No Show Policy
and
Notice of Privacy Practices

The Staff at *Rocky Mountain Spine and Sport* work hard to provide quality care and to give each patient the time required for their condition. We offer early morning and evening hours for those whose schedules do not allow treatment during the day.

As our business grows, it becomes increasingly important that we continue to offer treatment time slots that are as convenient as possible to our patients. **It is equally important that if you wish to cancel or reschedule an appointment that we receive at least *24 hours* notice so that we can call and schedule patients from our waiting list.** We do realize that scheduling conflicts and emergency situations occasionally arise and we will do our best to excuse these special circumstances.

A ***$25 Cancellation/No Show Fee*** will be charged to you directly. These fees ***cannot*** be billed to insurance.

A voice message on our phone is an acceptable means of communicating a cancellation.

Thank you in advance for your consideration.

I have read and understand *Rocky Mountain Spine and Sports* Cancellation and No Show policy.

_____ _____

Patient/Responsible Party Signature **Date**

Notice of Privacy Practices

I hereby acknowledge that I have read and received Rocky Mountain Spine and Sport, LLC's Notice of Privacy Practices.

_____

Printed Name of Patient

_____ _____

Signature of Patient or Guardian Date