PN:________________ MRN:________________

Consent of Care and Treatment

I, the undersigned, do hereby agree and give my consent for *Rocky Mountain Spine and Sport Physical Therapy, LLC.* 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, LLC,* as required, until further notice.

Patient/Guardian: _______________________________________**Date:** ____________________________________

Financial Policy Statement

Rocky Mountain Spine and Sport Physical Therapy, LLC. will submit your claims to your insurance company, on your behalf. You are responsible for the entire bill once services are rendered. We may require that arrangements for payment of your estimated share be made prior to the rendering of services, depending on your insurance benefits. 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, LLC.*

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

☐ Deductible $_______________ Amt Met $_______________ Amt Remaining $______________

☐ Co-Insurance _____________% Per Visit ***Visits Allowed: ___________ Used:___________ Hard:___Soft:___

☐ Co-Payment $_____________ Per Visit

☐ Out of Pocket $______________ Amt Met $_______________ Amt Remaining $______________

Patient Responsibility (Due at time of service)

☐ Patient will be paying $_________________ To be collected at each visit to be applied toward:

☐ Deductible ☐ Co-Insurance ☐ Co-Pay ☐ Out of Pocket

*The amount collected at time of service is determined by combining your Co-Pay, Co-Insurance and any unmet Deductible/Out of Pocket amounts. **As claims process, any balance remaining will be your responsibility, and billed to you.**

This information is not a guarantee of insurance coverage or benefits. This information is provided as a courtesy to you and was obtained from your insurance company. You are financially responsible for charges whether or not paid by insurance and cannot rely on this document as a guarantee of insurance coverage or benefits. We encourage you to verify coverage with your insurance company.

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

Patient/Guardian: ___________________________________**Date:** ____

PN:________________ MRN:________________

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____________________

PN:__________________ MRN:_________________

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 ______________________________

____

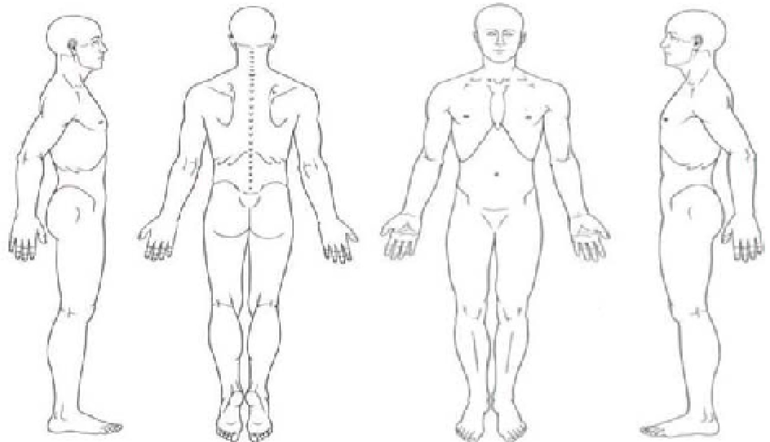
a. When did your symptoms start? ______________________________

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 *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

8. Who have you seen for your symptoms?

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

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 ② Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other

10. What is your occupation?

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

____

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

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

Patient Signature ______________________________ ***Date*** ______________________

PN:________________ MRN:________________

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