Financial Policy & Consents

Patients Name: _____ MRN: _____ PN: _____

Covered Benefits: As a courtesy, we will attempt to verify therapy benefits with your insurance carrier; however, verification is only an explanation of benefits based upon information that we receive from your insurance carrier. Verification is not a guarantee of payment, coverage or benefits. You are responsible for the payment of any deductible, co-payment/co-insurance, and any non-covered services as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. If your insurance carrier denies any part of your claim or if you continue therapy past your allowed/ approved visits, payment will be expected from you. Please contact your insurance carrier directly to confirm your individual benefits for Physical Therapy services.

Should my account become severely delinquent, I understand that I am responsible for all costs of collections including attorney fees, collection fees of 30% and court costs regarding my past due balance. I understand that any unpaid balance will be assessed interest at the rate of 18.00% (1.5% monthly).

It is my understanding that I am financially responsible to *Rocky Mountain Spine & Sport Physical Therapy* for the services provided to me or my dependent. I authorize my insurer to pay any benefits directly to *Rocky Mountain Spine & Sport Physical Therapy*. I agree to pay the full amount of all charges incurred by the named patient that are not covered by my insurance carrier.

Initials:_____

Consent to Provide Treatment: I hereby authorize *Rocky Mountain Spine & Sport Physical Therapy* through its appropriate personnel to perfom upon me, or the above named patient, appropriate assesments and treatment procedures.

Initials:_____

Attendance Policy: We take patient care seriously but understand that there are times when appointments must be missed. We request **24 hour notice** for cancellations. You may be assessed a $50 cancellation fee for cancellations without notice or reason. If you miss 2 or more consecutive appointments without contacting our office, all future appointments may be cancelled. If you arrive more that 10 minutes later than your scheduled appointment time, you may be asked to reschedule your appointment.

Initials:_____

Medical Release: I hereby authorize *Rocky Mountain Spine & Sport Physical Therapy* to release my medical records to physicians, insurance companies, and other agencies as necessary. I also authorize Rocky Mountain Spine & Sport Physical Therapy to obtain any portion of my medical record from any other institution that is deemed medically necessary in the course of my treatments.

Initials:_____

Communication Preferences: In caring for our patients, it may be necessary for our practice to contact you by automated calls to leave a message or text. When you are not available to speak to directly, we like to leave messages when possible. In order to protect your privacy, it is our policy to not leave specific information on an answering machine/voice mail system, unless we have permission to do so.

I give consent to receive text, email, and/ or phone messages from *Rocky Mountain Spine & Sport Physical Therapy* regarding appointment reminders, confirmations, surveys and other communications specific to the above named patient.

** Data and messaging Rates May Apply **

Initials:_____

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

Initials:_____

I have read the above statements and understand and agree to the responsibilities of my (or my dependents) account.

Patient or Parent/Guardian Signature: _____ Date: _____

Rocky Mountain SPINE & SPORT Physical Therapy

Medical History Intake

MRN: _____ **PN:** _____

Family/Personal History

Patients 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

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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 or Parent/Guardian Signature: _____ **Date:** _____

Patient Health Questionnaire - PHQ

Patients Name: _____ MRN: _____ PN: _____

1. Describe your symptoms _____

_____

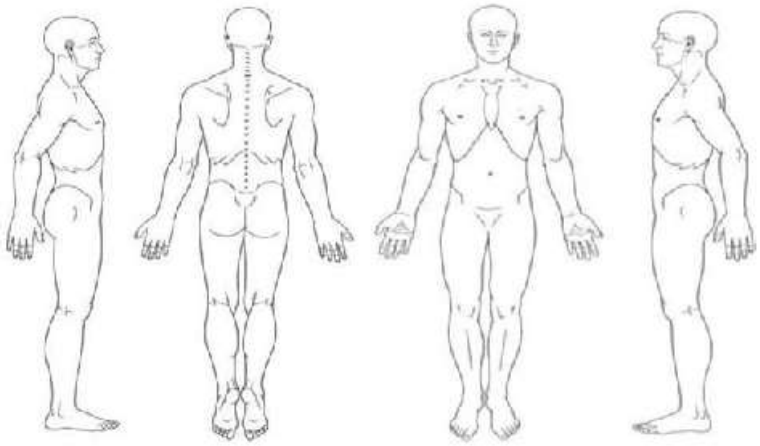
a. When did your symptoms start? _____

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 ⑤ Shooting
② Dull ache ⑥ Burning
③ Numb ⑦ 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 ⓪ 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
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 or Parent/Guardian Signature: _____ **Date:** _____