AVALANCHE PHYSICAL THERAPY & SPORTS REHABILITATION

Patient Information Form:

Name: _____ Date of Birth: _____

Phone #: _____ Email: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

SSN: ____-____-_____

Referring Doctor: _____ Post-Op: □Yes □No

Type of Insurance: (Please Circle One)

BCBS UHC UMR Cigna Medicare Medicaid
Bright Health Humana Other:

Member ID/Policy #: _____

Group #: _____

Policy Holder: _____

Policy Holder Date of Birth: _____

Relationship: _____

****Guarantor Information (if under 18 OR has a Signee)**

Parent/Guardian Name: _____ DOB: _____

All the above information is true and accurate to the best of your knowledge.

Signature: _____ Date: _____

AVALANCHE PHYSICAL THERAPY & SPORTS REHABILITATION

Financial Policy

Name of Patient: _____

Avalanche Physical Therapy appreciates the confidence you have shown in choosing us to provide for your rehabilitative needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf.

However, you are ultimately responsible for the payment of your bill.

We will adhere to the following financial policy in order to consistently deliver high quality care and services. The patient/responsible party assumes responsibility to ensure that the financial obligation is fulfilled for the health care services received.

- I understand that I am responsible for all co-payments, amounts applied to deductibles, and other amounts that may be deemed my responsibility by the payment sources, as required by my contact with my insurance plan and state regulations.
- I understand that if I have an insurance co-payment, I am expected to make payment when checking in for my appointment.
- I understand that my contract with my insurance entity may or may not cover some services. All insurance policies are not the same, they vary by insurance. Avalanche Physical Therapy is not responsible or able to know every policy available. It is my responsibility to verify applicable coverage prior to receiving the services. If I seek care outside of the contract terms, I am aware that I may be responsible for all charges that are incurred. If you and/or your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full.
- Payment is expected by the payment due date listed on your statement. If you need assistance, please call the billing department at 970-623-7030.
- I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I consent to assign all payments for services directly to this practice. I further consent to the use of my information or any practice operational needs as identified in the Practice Privacy Notice.

Name of Insurance: _____

Co-Payment _____ / Visit

Co-Insurance _____ % of allowed amount

Deductible Amount _____ Amount Not Met _____

Maximum Visits / Days _____ Per Person / Condition / Year / Lifetime

Out of Pocket Maximum _____ Amount Not Met _____

Other Benefit Information: _____

I have read and understand my insurance benefits as described above. I understand this is not a guarantee of coverage or payment by my insurance company. I further understand I am ultimately responsible for the payment of my bill.

Signature: _____ (relationship to patient: _____) Date: _____

Optional

CREDIT CARD ON FILE AGREEMENT

Yourcreditcard on file willbeused forallchargesincurred for services at Vail Summit Physical Therapy dba Avalanche Physical Therapy. If you are covered by insurance your credit card will be processed for your co-pay on the date of service. If your insurance policy requires a deductible or co-insurance your credit card will only be charged after the claim has been filed and processed by insurance. If you are a self pay patient your services will be charged to your credit card upon completion of your daily visits, Upon request a receipt maybe given or mailed to you after any charge has been made to your credit card.

Please complete the following if you would like us to provide this service to you:

I authorize Vail Summit Physical Therapy dba Avalanche Physical Therapy to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

Credit Card Number:

_____

Expiration Date: _____ / _____ / ____ 3 Digit Code: _____

Cardholders Name: _____

Address: _____

City _____ State_____ Zip _____

I (we), the undersigned, authorize and request Vail Summit Physical Therapy dba Avalanche Physical Therapy to charge my credit card, indicated above, for all balances due for any services rendered including those that my insurance company identifies as my financial responsibility.

This authorization includes all fees not covered by my insurance company for services provided to me by Vail Summit Physical Therapy dba Avalanche Physical Therapy.

This authorization will remain in effect until I (we) cancel this authorization. To cancel this service, written notification must be given to Vail Summit Physical Therapy dba Avalanche Physical Therapy.

Patient Name (Print):_____

Patient Signature_____Date_____

CANCEL THE ABOVE AUTHORIZATION EFFECTIVE AS OF THIS DATE: _____/_____/_____

Patient Name (Print): _____

PATIENT SIGNATURE: _____DATE: _____

NOTICE OF PRIVACY PRACTICES & FEDERAL RIGHTS

I acknowledge that the Notice of Privacy Practices and Notice for Federal Civil Rights is posted at the location in which I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have the right to request a copy of the notice and one will be provided to me.

Signature:_____(relationship to patient:_____) Date: _____

CONSENT OF TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I am aware of my diagnosis and voluntarily consent to have Avalanche Physical Therapy, through its appropriate personnel, provide evaluation and/or treatment as prescribed by my physician and/or recommended by my therapist. I understand the practice of physical, speech, and occupational therapy is not an exact science, and I acknowledge that no guarantees have been given to me regarding the successful completion or the results of the treatment provided. I understand that the treatment I receive from Avalanche Physical Therapy is limited to physical, speech, and/or occupational therapy services and that I shall seek treatment from other medical professionals for all other issues I may experience. I understand that I have the right to ask questions at any time during the course of my care.

Signature:_____(relationship to patient:_____) Date: _____

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Authorization for Release of Information

Patient Name _____DOB_____

Avalanche Physical Therapy is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.
I authorize Avalanche Physical Therapy to provide or discuss my care and my account to the following people. This may be through phone, fax, e-mail or voice mail unless otherwise specified.

Patient Information I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. *I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.* This authorization shall be in effect until revoked by the patient.

Signature of Patient or Personal Representative Date

AVALANCHE PHYSICAL THERAPY & SPORTS REHABILITATION

Cancellation/No-Show agreement

Avalanche Physical Therapy, strives to provide each patient with the highest quality of care while attempting to accommodate your schedule for your convenience. Your consistent attendance of the planned treatment regime is paramount to your recovery.

Cancellations, especially last minute ones, along with patient no-shows, hinder our ability to accommodate the scheduling needs of our other patients. Therefore, we must ask for your full cooperation with the following policy:

- If you are unable to keep a scheduled appointment, we request that you notify us no less than 24 hours in advance so that your appointment can be rescheduled and enable us to open that slot for someone else in need.

- A $25 cancellation/no-show charge will be applied to your next visit if we do not receive appropriate notice. All charges will be payable prior to continuing your therapy. _____(Initial)

- All no-shows and cancellations will be documented in your medical record and appropriately reported to your physician, insurance carrier, and adjuster or case manager as applicable. Three (3) missed appointments constitutes non-compliance and may result in the discharge of your therapy program.

We believe that this policy is necessary for the benefit of our patient care as a whole so that we may continue to provide quality services convenient for all.

We appreciate the opportunity to be a part of your rehabilitation and wish you a speedy recovery.

Thank you for your anticipated cooperation and consideration for our staff and other patients.

Patient Agreement:_____ Date: _____

Medical History Form

AVALANCHE PHYSICAL THERAPY & SPORTS REHABILITATION

Patient Name:_____ Today's Date:_____

Height:_____ft _____in Weight:_____(pounds) Date of injury:_____

Diagnosis as stated to you by your physician: _____

How did this injury/ exacerbation occur? _____

Have you been hospitalized for the present condition? □ Yes □ No If Yes, date:_____

Have you had surgery for the present condition? □ Yes □ No If Yes, date:_____

If yes, surgery type:_____

Have you had any falls this past year? □Yes □No If Yes, how many?_____

If yes, date and summarize:_____

Have you received previous treatment for this condition? □ Yes □ No

Have you ever had any of the following? □ EMG □ CT SCAN □ MYELOGRAM □ MRI □ XRAY

Have you ever, or are you presently being treated for any of the following conditions? Check YES if it applies

Acquired Respiratory Distress Syndrome	□ Yes	□No
Angina	□ Yes	□No
Anxiety or Panic Disorders	□ Yes	□No
Arthritis (RA, OA)	□ Yes	□No
Asthma	□ Yes	□No
Chronic Obstructive Pulmonary Disease (COPD)	□ Yes	□No
Congestive Heart Failure (CHF)	□ Yes	□No
Degenerative Disc Disease (back disease, spinal stenosis, severe chronic back pain)	□ Yes	□No
Depression	□ Yes	□No
Diabetes	□ Yes	□No
Emphysema	□ Yes	□No
Hearing Impairment	□ Yes	□No
Heart Attack	□ Yes	□No
Multiple Sclerosis	□ Yes	□No
Osteoporosis	□ Yes	□No
Parkinson's Disease	□ Yes	□No
Peripheral Vascular disease	□ Yes	□No
Stroke or TIA	□ Yes	□No
Upper Gastrointestinal Disease (ulcer, hernia, reflux)	□ Yes	□No
Visual Impairment (cataracts, glaucoma, macular degeneration)	□ Yes	□No

Allergies	□ Yes	□No
Headaches	□ Yes	□No
Back Injury	□ Yes	□No
Bleeding Disorders	□ Yes	□No
Bowel / Bladder Abnormalities	□ Yes	□No
Cancer	□ Yes	□No
Dizzy or Fainting Spells	□ Yes	□No
Epilepsy or Seizure Disorder	□ Yes	□No
Fracture	□ Yes	□No
Hepatitis A, B, C	□ Yes	□No
Hernia	□ Yes	□No
High Blood Pressure	□ Yes	□No
Hypoglycemia	□ Yes	□No
Immunosuppressant Condition or Medication	□ Yes	□No
Kidney Problems	□ Yes	□No
Liver / Gallbladder Problems	□ Yes	□No
Metal Implants	□ Yes	□No
Nausea / Vomiting	□ Yes	□No
Pacemaker	□ Yes	□No
Pregnancy	□ Yes	□No
Ringing in Your Ears	□ Yes	□No
Sexual Dysfunction	□ Yes	□No
Skin Abnormalities	□ Yes	□No
Smoking	□ Yes	□No
Special Diet Guidelines	□ Yes	□No
Tuberculosis	□ Yes	□No

Please continue to 2nd page

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Patient Name: _____ Date: _____

Are you on any medications?

_____

_____

To help us understand your symptoms, please circle all that apply.

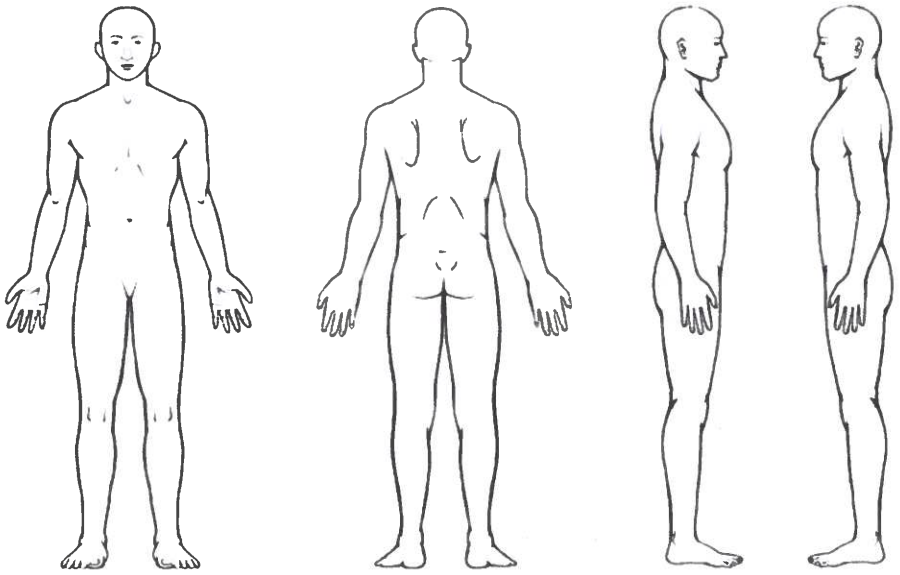
My pain is worse: in the morning/ during the day/ at night/ constant/ with activity/ during rest

On a scale of 0 to 10 (0 being no pain and 10 being unbearable pain, requiring hospitalization)

Please rate your current level of pain_____ Rate your pain level at its worst_____

Pain Diagram

Using the key provided, please draw the symbol representing your pain over the area of the body as it relates to your present condition



Key

↑ or ↓ Radiating Pain

XXXX Spasm

ZZZZ Tenderness

//// Numbness/Tingling

0000 Ache/Pain

Is there any other important information regarding your medical history that we should know about?_____

What is your goal for therapy at this time? _____

Signature of Patient or Guardian (if patient is a minor):_____Date: _____

Signature of clinician: _____