



Rock Springs Clinic
 1977 Dewar Drive Suite J
 (307) 382-3228 Phone
 (307) 382-6886 Fax

Green River Clinic
 520 Wilkes Drive Suite 17
 (307) 875-1788 Phone
 (307) 875-8817 Fax

Lyman Clinic
 109 S Main Street Suite D
 (307) 787- 3278 Phone
 (307) 787- 3145 Fax

Date: / /

Patient History

Patient Name: _____ Date of Birth: / / Social Security: / / Marital Status: S M D W Sex: M F

Billing/Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: () Cell Phone: () Work Phone: () Email: _____

Employer: _____ Emergency Contact: _____ Relationship to Patient: _____ Telephone: ()

Referring Doctor: _____ Date of Injury: / / Date of Surgery: / /

How did you hear about us?

- Physician/ Hospital Internet Search Returning Patient Word of Mouth Other _____

Insurance

Primary Insurance Company:

Policy Holder: _____ Policy Holder DOB: / / Social Security: _____ Policy Holder Relationship to Patient
 Self Spouse Parent Other

Secondary Insurance Company:

Policy Holder: _____ Policy Holder DOB: / / Social Security: _____ Policy Holder Relationship to Patient
 Self Spouse Parent Other

Other Insurance Company:

Policy Holder: _____ Policy Holder DOB: / / Social Security: _____ Policy Holder Relationship to Patient
 Self Spouse Parent Other

Workers Compensation/ Auto Accident/ Other

Injury Type: Work Related? Yes No Auto Accident? Yes No Other Accident? Yes No

Date of Injury: / / Claim Number: _____

Case Manager Name:	Brief description of accident: (Where you were? How it happened?)
Case Manager #:	

Medications

Are you currently taking medications? If yes, please list below

Medication	Dosage	Frequency of Dosage

Check if you have provided a medication list to the front office to scan into chart

Patient Health History

Name: _____

Height: _____

Weight: _____

Age: _____

Family Physician: _____

Please mark if you currently have/had any of the following:

- | | | |
|---|---|--|
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> History Of Cancer | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Huntington's | <input type="checkbox"/> Asthma/Allergies |
| <input type="checkbox"/> Cauda Equina Syndrome | <input type="checkbox"/> Immunosuppression | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Cerebral Vascular Accident | <input type="checkbox"/> Lupus | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Current Infection | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Currently Pregnant |
| <input type="checkbox"/> Diabetes Mellitus Type 1 | <input type="checkbox"/> Obesity | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Diabetes Mellitus Type 2 | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Lung Disease/Problems |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Heart Disease/Problems |
| <input type="checkbox"/> Fracture Or Suspected Fracture | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Circulation/Bleeding Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Traumatic Brain Injury | <input type="checkbox"/> Epilepsy/Seizures |

Primary Concern/ Chief Complaint:

When did the symptoms appear?: _____

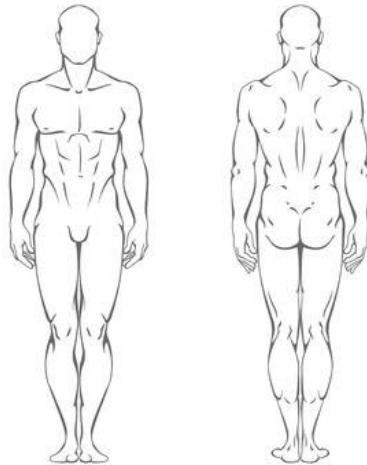
Is this condition getting worse?

- Yes No Same

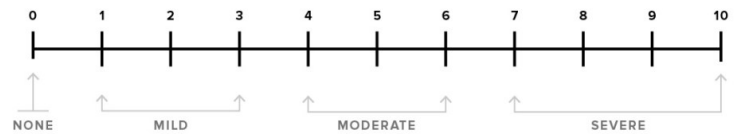
Are you currently working? Yes No

Mark on the diagram below the areas currently affected by your condition

- X-Pain**
0-Numbness
!!-Pins & Needles



Please indicate your pain level on the scale below



Please circle which goals you wish to achieve from attending therapy:

- | | | |
|--|--|--|
| <input type="checkbox"/> Regain Mobility & Strength | <input type="checkbox"/> Return to work | <input type="checkbox"/> Decrease pain |
| <input type="checkbox"/> Regain previous level of activity | <input type="checkbox"/> Maintain independent daily living | <input type="checkbox"/> Other: _____ |

Falls (please check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> I have no falls | <input type="checkbox"/> I fall occasionally | <input type="checkbox"/> I have just started to lose my balance |
| <input type="checkbox"/> I fall frequently (more than twice in the last 6 months) | <input type="checkbox"/> Certain factors make me cautious (curbs, ice, stairs, and getting out of the tub) | |

What treatments have you already received for your condition?

- Surgery Physical Therapy Chiropractic Other

Please list past surgeries and dates:

1. _____	4. _____
2. _____	5. _____
3. _____	6. _____



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Consent to Treatment: I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examination and treatment. I have received and/or read a copy of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Policy.

Financial Responsibility and Assignment of Benefits: I understand and agree that, I am ultimately responsible for the balance of my account for any professional services rendered, durable medical equipment (DME) fit, or splints applied. If I choose to not pay any outstanding balance, I could be responsible for court costs and attorney's fees, and interest charges of 1.5% monthly or 18% annually on any outstanding balance not paid that is sent to small claims court. In the event of collection procedures, attorney fees and court costs are your responsibility. I also understand that the delinquency fee with regards to collections will be equal to 50% of the principal amount owed.

- 1. Co- Payments: Co-Payments are due at the time of service.
2. Workers Compensation Claims: We submit claims to workers compensation. However, if we received subsequent denials, you will be responsible of the total amount of charges.
3. Self-Pay Policy: \$125 for the initial evaluation \$100 for each session after the evaluation. Payment is due at the time of service.
4. Auto Claims: We submit claims to auto insurance. However, if benefits are exhausted or they pay you first you are responsible of the service charges.
5. Cancellation/No Show Policy: We require 24 hours notice in the event of a cancellation. After 3 such instances I understand that I may be formally discharged as a patient and my Doctor or Case Manager will be notified of this action.

Release of Medical Records (optional)

I hereby authorize Alliance Physical Therapy, LLC to release confidential health information about me, by releasing a copy of my medical record or summary or narrative of my protected health information to the physician/ person/ facility/entity:

Send Information To:

Name/Office:

Phone:

Address:

Fax:

I certify that I have read this form and understand its contents.

Patient/Parent/Guardian Signature

Date

Printed Name

Relationship to Patient