Alliance
THERAPY & CHIROPRACTIC
www.aptwy.com

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

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Patient Health History

Name:

Height: **Weight:** **Age:** **Family Physician:**

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

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

Primary Concern/ Chief Complaint:

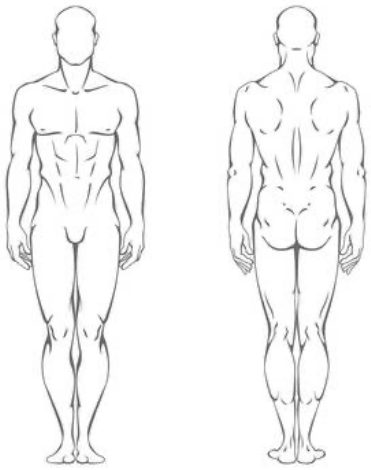
When did the symptoms appear?:

Is this condition getting worse?
□ Yes □ No □ Same

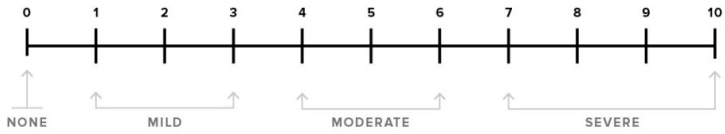
Are you currently working? □ Yes □ No

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:

- □ Regain Mobility & Strength
- □ Regain previous level of activity
- □ Return to work
- □ Maintain independent daily living
- □ Decrease pain
- □ Other:

Falls (please check all that apply)

- □ I have no falls
- □ I fall occasionally
- □ I have just started to lose my balance
- □ I fall frequently (more than twice in the last 6 months)
- □ 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:** Payment is due at the time of service.

Physical & Occupational Therapy		Chiropractic		Massage Therapy		Dry Needling	
Initial Eval	$125	Initial Eval	$75	30 min	$40	30 min Session	$75
Session	$100	Session	$50	60 min	$75	15 min Session	$50
				90 min	$115		

4. **Auto Claims:** We submit claims to auto insurance. However, if benefits are exhausted or they pay you first you will be responsible of the total amount of 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.
6. **Timely Filing:** It is your responsibility to provide ALL insurance cards within 1 week of your initial appointment. You will be responsible of the total amount of charges if it is not provided in a timely manner.

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