Patient Information

Name: ______________________________
First Middle Last

Date of Birth: Height: Weight: Social Security:

Street Address:

City: State: Zip:

Email:

Check to receive monthly clinic newsletter

Phone: (home) (mobile) (work)

Would you like us to provide appointment reminders by? Voicemail Email

Employer:

Referring Physician:

Primary Physician: Date of last Physician Exam:

How did you hear of us?

Emergency Contact

Contact Name: Relationship:

Phone: (home) (mobile) (work)

Consent to Treatment

*I authorize Sapphire Physical Therapy to treat me/my child. I understand methods of treatment may include, but are not limited to: Therapeutic Exercises, Manual Therapy and other modalities as deemed appropriate by my Physical Therapist per standard of care.

*I understand that I am responsible for all charges incurred regardless of insurance or third party liability.

*I authorize contact by the use of my mobile/cell phone number for discussing treatment, confirming appointments and resolution of the balance of my account.

*I authorize Sapphire Physical Therapy to release any medical information necessary to process my claim to my insurance company or to any other concerned third party.

*I understand that I will bear the cost for all associated collections and/or attorney/legal fees if my account is placed with a 3rd party agency and/or attorney for collections or legal action.

*I authorize my insurance company or any other concerned third party to make payment directly to Sapphire Physical Therapy.

*For patients under 18 years of age; the parent, relative or person *escorting* the patient is responsible for any payments due at the time of the service.

Signature ______________________________ **Date** ______________

IF PATIENT IS UNDER THE AGE OF 18

Mother's Name ______________________________ Employer ______________________________

Work # ______________________________ Social Security # ______________________________

Father's Name ______________________________ Employer ______________________________

Work # ______________________________ Social Security # ______________________________

History of Present Problem

What is the main reason for your Physical Therapy evaluation today?

When did you first notice the problem?

Days ago | Weeks ago | Months ago | Years ago

Other:

Do you have any other symptoms?

No | Yes(Please explain):

How does the problem interfere with daily functions?

No | Yes(Please explain):

Have you had any falls this past year? | No | If yes, how many?

Have you had any diagnostic testing for your present injury/issue? (MRI, Xray, CT,ect.)

Problem **worsens** with: (check all that apply)

Movement	Standing	Morning	Other:
Bending	Lying	Evening	
Walking	Sitting	As the day progresses	
Turning	Rest	Interrupts Sleep	

Problem **improves** with: (check all that apply)

Movement	Standing	Rest	Medication
Inactivity	Lying	Heat	Morning Other:
Walking	Sitting	Ice	Evening
Turning	Bending	Exercise	As the day progresses

On a scale of 0-10 (0 is no pain, 10 is worst pain imaginable), check the number that best describes:

Your current pain?

0 1 2 3 4 5 6 7 8 9 10

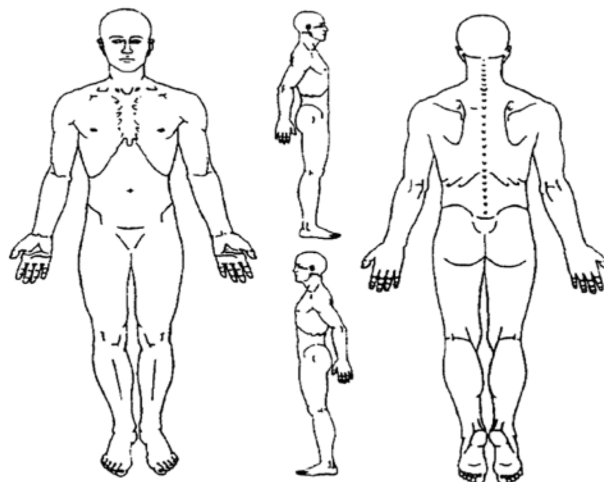
At worst?

0 1 2 3 4 5 6 7 8 9 10

At best?

0 1 2 3 4 5 6 7 8 9 10

Please mark the location of the pain on the diagram below.



How frequently are you bothered by this problem?

Constant

Intermittent

Other:

How would you describe the pain? (Check all that apply)

Dull/Achy	Burning	
Sharp	Throbbing	
Dull then Sharp	Shooting	
Constant	Numbness/Tingling	
Worse in morning	Worse at Night	Intermittent

Personal Medical History: Please check any that apply to ***you*** .

Diabetes(type I or II)	Hernia	Seizures/Epilepsy
Arthritis (RA/OA)	Fibromyalgia	TBI
Tuberculosis	Autoimmune Disorder	Pacemaker
Breast Cancer	Other Cancer	Hepatitis(A,B,C)

Other Chronic, Recurrent or Severe Illness(es):

Review of Systems

Do you now or have you had any problems related to the following systems?

Please check all that apply, if other please explain.

Allergic/Immunologic

Hay Fever
Drug Allergies
Asthma
Other: ______________________

Ear/Nose/Throat/Mouth

Ear Infection
Sore Throat
Sinus Problems
Other: ______________________

Respiratory

Wheezing
Frequent Cough
Shortness of Breath
Pneumonia
Other: ______________________

Constitutional Symptoms

Fever
Chills
Headache
Night pain
Other: ______________________

Musculoskeletal

Joint Pain
Neck Pain
Back Pain
Muscle Pain
Other: ______________________

Gastrointestinal

Abdominal Pain
Nausea/Vomiting
Indigestion/Heartburn
Other: ______________________

Hematologic/Lymphatic

Swollen glands
Cysts
Blood clotting problem
Other: ______________________

Eyes

Blurred Vision
Double Vision
Pain
Other: ______________________

Endocrine

Excessive thirst
Too hot/cold
Tired/Sluggish
Other: ______________________

Integumentary

Skin Rash
Boils
Persistent Itch
Other: ______________________

Genitourinary

Kidney Disease
Urinary Retention
Painful Urination
Urinate Frequently
Incontinence/Leaking
Other: ______________________

Neurological

Tremors
Dizzy Spells
Numbness/Tingling
Other: ______________________

Cardiovascular	**Psychologic**		
Chest Pain	Are you generally satisfied with your life?	Yes	No
Stroke	Have you considered suicide?	Yes	No
Varicose Veins	Do you suffer from depression?	Yes	No
Deep Vein Thrombosis			
High Blood Pressure			
Heart Disease			
Pulmonary Embolism			
Blood Thinners			
Congestive Heart Failure			
Other: ____________			

List all health conditions in your ***family.*** (Example: Diabetes, Tuberculosis, Breast Cancer, Heart disease, etc.)

____

____

Are you on any prescription medications?	No	Yes(Please list all or provide list)
Name	Dose	Frequency

Any over the counter medications?No Yes, please explain: ____________

Do you have any allergies? No Yes, please explain: ____________

How much caffeine do you consume daily? No Yes, How much? ____________

Do you drink? No Yes, How much? ____________

Do you use nicotine? No Yes, How much? ____________

Cigarettes E-Cig Chew Cigars Patch

Do you have any other conditions that may limit your response to exercise? No

Yes, please explain: ____________

Have you had any recent illnesses within the past 2-3 weeks? (i.e. Colds, flu, bladder/kidney infection.) No

Yes, please explain: ____________

Have you noticed any lumps or thickening of skin or muscle anywhere in your body? No

Yes, please explain: ____________

Do you have any sores which haven't healed or any changes in size, shape or color of wart or mole? No

Yes, please explain: ____________

Do you have any special needs and or considerations? No

Yes, please explain: ____________

What are your hobbies/recreational activities? No

____

What is your goal for therapy at this time? ____________

____

Have you had any unexplained weight loss or gain in the last month? No

Yes, please explain: ____________

Is there a possibility that you may be pregnant? Yes No

Sapphire Physical Therapy Financial Policy

By executing this agreement, you are agreeing to pay for all services that are received.

Please select the option(s) you prefer:

Payment options if you DO NOT have insurance:

1. You choose to pay by cash, check, or credit card at the time the services are rendered. Our cash payment option for patients without insurance is $125 per visit. Payment is expected at time of service. If extenuating circumstances should arise, you can discuss a payment plan with our Practice Manager, Jennifer Blank.

Payment options if you DO HAVE insurance:

1. If you still have a ***deductible to meet***, you choose to pay $125 by cash, check, or credit card at the time services are rendered. We will send your claim to your insurance carrier and will bill you for additional patient responsibilities, if any, which will be determined by your carrier.

2. You choose to pay your ***co-payment and/or coinsurance***, determined by your insurance carrier, by cash, check, or credit card at the time services are rendered. If there is a balance on your account at the end of the month we will bill you accordingly. Any balances without a payment within 30 days of the date of service will be charged a recurring $6 monthly re-billing/finance charge until services are paid in full.

I will make payments at time of service
I will make a payment arrangement for my account
Work Related (My workers compensation carrier authorized physical therapy)
Motor Vehicle (A motor vehicle insurance company authorized physical therapy)

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance/rebilling charge, if any, and any payments or credits applied to your account during the month.

Payments: Unless other arrangements are approved by either John Fiore, Owner or Jennifer Blank, Practice Manager, the balance of your statement is due and payable when the statement is issued and is past due if not paid by the end of the month.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid in full at the time of service.

Finance Charge: A finance charge will be imposed on your account when it has not been paid within (30) days of the statement date. The finance charge will be $1 per billing period and will accrue every (30) days when a payment has not been made on your account.

Re-billing Fee: A re-billing fee of $5 will be imposed on each account that is over (30) days past due and a payment has not been made, unless other payment arrangements and a payment plan have been agreed upon.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. We reserve the right to refer your account to an attorney or collection agency. You agree to pay all attorney fees and collection costs incurred in enforcing the terms of this agreement.

Returned Checks: There is a $25 fee for any checks returned by your bank.

Workers Compensation: We require written approval/authorization by your worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for your payment in full.

Motor Vehicle Accidents: If the insurance policy involved in any motor vehicle accident claim does not accept liability for your claim, you will be held responsible for your payments in full.

No Show/Cancelled Appointments: We reserve the right to charge a $20 fee for a third consecutive no show/cancelled appointment. The fee must be paid before a new appointment is scheduled. We also may ask you to switch to same day only scheduling. We require a 24 notice for all cancellations.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's name: ____Date:_____________

Responsible Party: ____
(if not the patient)

Signature: ____

RELEASE OF INFORMATION

Sapphire Physical Therapy
1705 Bow St.
Missoula, MT 59801
(406) 549-5283
(406) 549-5392 fax

Thank you for referring your patient to Sapphire Physical Therapy.

Please forward the medical records regarding this patient so we may provide proper treatment to your patient.

I authorize the release of and correspondence regarding my (or my dependent's) medical records to Sapphire Physical Therapy.

Date ______________________________

Patient Name ______________________________

Date of Birth ______________________________

Signature ______________________________ **Date** ____________________

NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient, and our common practices in dealing with patient health information

Uses and Disclosure of Health Information:
We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization:
Except as stated in more detail in the Notice of Privacy Practice, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring your Authorization:
In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care
- For certain limited research purposes
- For purpose of health and safety
- To Government agencies for purposes of their audits, investigations, and oversight activities
- To Government authorities to prevent child abuse and domestic violence
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders
- When required by court orders, search warrants, subpoenas, and as otherwise required by law

Patient Rights:
As our patient, you have the following rights:

- To have access to and/or copies of your health information
- To receive an account or certain disclosures we have made of your health information
- To request restrictions as to how your health information is used or disclosed
- To request that we communicate with you in confidence.
- To request that we amend your health information
- To receive notice of our privacy practices

Please contact us with any questions, concerns, or complaints regarding our privacy practices.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the Notice.

____
Patient Name (Please Print)

____
Parent or Authorized Representative (if applicable)

____
Signaure **Date**