THANK YOU FOR CHOOSING RIDGEVIEW PHYSICAL THERAPY, PLLC.
We are dedicated to your entire experience here being successful.

Review Your "Schedule of Benefits." You should call your insurance company with any specific questions regarding your Outpatient Physical Therapy Coverage. You need to accurately verify and understand your policy's deductible, co-payment, coinsurance, visit limitations, effective annual calendar renewal date, and any pre-authorization requirements. As a courtesy, we will also verify your coverage, but we will not guarantee the accuracy of the information we receive. Your insurance policy is a contract between you and your insurance company. You are responsible to know your level of coverage, and you are ultimately responsible for the full payment of your bill.

Insurance Information: We need complete and accurate information about your policy We will submit claims to your health insurance company for you. You are responsible for payment of any deductible, co-pay, and co-insurance as determined by your contract with your insurance company. If your insurance company requires you to have a referral from your primary care physician, you will need to have that faxed to our office or brought with you to your appointment. As a courtesy, we will contact your primary care or the referral but it is ultimately your responsibility to make sure the referral is issued.

Secondary Insurance: If you have secondary insurance, you must present it at your initial visit. The same policies and responsibilities apply to the use of secondary insurance. You are responsible for the accuracy of the insurance information we use to submit the claim, and you are ultimately responsible for the full payment of your bill.

Changes in Coverage: It is your responsibility to inform us of any and all changes of insurance coverage during the course of treatment. Failure to do so may result in denial of coverage by your insurance company.

Worker's Compensation: If you are claiming worker's compensation you must provide us with a copy of your personal insurance card. We will confirm your authorization with your case adjuster or case manager. In the event of your worker's compensation carrier denies payment for your claim, we will file the claims with your personal insurance policy. If your claim is denied by your personal insurance you are responsible for the full payment of your bill.

Payment: Balances will be considered current from the date your insurance pays its portion. After that, the payment is due upon receipt of a statement from our office.

Please continue on the back page for signature

Personal Injury, Liability, Auto, or Involvement of an Attorney: you need to complete and sign all of the patient registration forms. You must still provide us a copy of your personal insurance card. In the event your claims are denied by the liability carrier or that the personal injury protection benefits are exhausted, we will file claims with your personal health insurance policy If your personal insurance policy denies the claim for any reason, you are responsible for the full payment of your bill.

Collections: We will work with you to avoid sending your account to collections. In the event of default on your account, your account will be turned over to our collection agency. If payment arrangements are not kept up on a timely basis and your balance, no matter what the amount, becomes more than 120 days old, we will proceed to send your balance to our collection agency.

Appointment Cancellation: If you cannot keep your appointment, we ask 24 hours' notice be given when possible. There is a $50.00 service charge for an appointment missed without notice.

Consent for Care/Treatment: I hereby agree and give my consent for RidgeView Physical Therapy, PLLC. to furnish medical care and treatment to me in accordance with my Doctor's prescription or other treatment considered necessary and advisable by the provider who attends me. I will have to opportunity to refuse any part of the treatment.

Release of Information: I authorize RidgeView Physical Therapy, PLLC. to release my medical records to my referring physician, insurance company/payer to facilitate my care.

I _____, consent to have the following additional persons given information regarding my condition and or my account.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I have read and understand the above Financial Policy, Cancellation Policy, Consent for Care/Treatment, and Release of Information and agree to the conditions listed above.

HIPAA Privacy Policy: By signing below you agree to the above policies. A hard copy of our private policy is available at any time upon your request.

Signature (Circle relationship to patient: Self / Guarantor / POA / Other: _____)

Date: _____

RidgeView
PHYSICAL THERAPY

MRN **Date**

PATIENT INFORMATION

Last Name **First Name** **Middle Initial** **Nickname/AKA**

Date of Birth **Social Security Number** **Gender** ❑ Male ❑ Female

Marital Status ❑ Married ❑ Single ❑ Divorced ❑ Life Partner ❑ Separated ❑ Widowed ❑ Other **Language** other than English

Home Address **Apt #** **City** **State** **Zip Code**

Home Phone **Work Phone** **Other Phone** ❑ Cell ❑ Pager ❑ Fax

Email Address **Employment Status** ❑ Active Duty Military ❑ Child ❑ Disabled ❑ Employed Full-Time ❑ Employed Part-Time ❑ Homemaker ❑ Not Employed ❑ Retired ❑ Self Employed

Employer **Employer Phone**

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician **Referring Physician**

How did you hear about us? ❑ Billboard ❑ Employer ❑ Family Member ❑ Friend ❑ Health Fair Event ❑ Insurance ❑ Magazine ❑ Mail ❑ News ❑ Physician ❑ Radio ❑ Television ❑ Website ❑ Yellow Pages ❑ Other

INSURANCE/CLAIM INFORMATION

Primary insurance **Secondary insurance** **Responsible party insurance or self?**

Have you had Physical Therapy this year? Are you in a hospice Program? Y N

Did your injury occur on the job? Y N **Date of injury** **Claim number** **Workers compensation Insurer** **Contact Number**

Did Your injury occur in a motor vehicle accident? Y N **Date of accident**

Is an attorney involved? Y N If so, their name is:_____

Are you receiving, or recently received Home Health Care Services? Y / N. If so provide date of discharge:

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name **First Name** **Relationship to Patient**

Address **Apt #** **City** **State** **Zip Code**

Home Phone **Work Phone** **Other Phone** ❑ Cell ❑ Pager ❑ Fax

RidgeView
PHYSICAL THERAPY

Name: _____ **Date:**_____ **Ht.**_____ **Wt**_____ **Age**_____

Have you RECENTLY noted any of the following (check all that apply)?

- ❑ changes in bowel or bladder function
- ❑ nausea/vomiting
- ❑ dizziness/lightheadedness
- ❑ difficulty maintaining balance while walking
- ❑ weight loss/gain
- ❑ shortness of breath
- ❑ headaches
- ❑ changes in appetite
- ❑ fever/chills/sweats
- ❑ pain at night
- ❑ weakness/fatigue
- ❑ difficulty swallowing

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer (type)_____
- ❑ heart disease
- ❑ high blood pressure
- ❑ asthma
- ❑ pacemaker inserted
- ❑ osteoporosis
- ❑ chemical dependency (i.e., alcoholism)
- ❑ rheumatoid arthritis
- ❑ stroke
- ❑ depression
- ❑ anemia
- ❑ lung problems
- ❑ thyroid problems
- ❑ other_____
- ❑ diabetes
- ❑ multiple sclerosis
- ❑ kidney/liver problems
- ❑ stomach ulcers
- ❑ epilepsy
- ❑ Parkinson's disease
- ❑ other_____

Have you fallen in the past year?____if so, how did it happen?_____were you injured?_____Please list current medications:_____ Are you currently taking blood thinning or anticoagulant medications for any medical conditions? **YES NO**

What Brings you to Physical Therapy today? _____

How did it start (gradually.suddenly,injury, surgery)?_____Date of onset_____

Have you had X-rays, MRI or other tests _____

What treatments have you received for this condition_____

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. _____ 2._____ 3._____

Pain Currently: Rate your level of pain at this time.

0 1 2 3 4 5 6 7 8 9 10

No pain worse pain

Worse pain in the last 24 hours

0 1 2 3 4 5 6 7 8 9 10

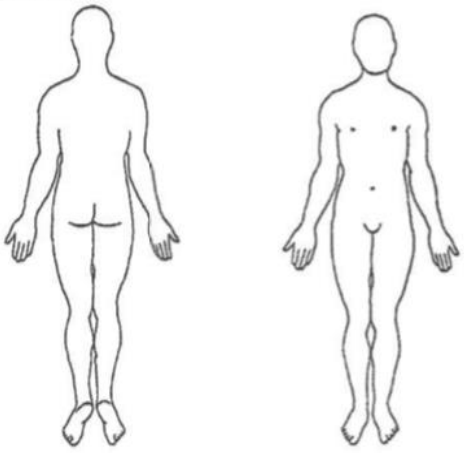
Body Chart:

Please mark pain location

X sharp stabbing
O Dull achy pain

....Numb/Tingling

/// Throbbing
== Burning



List 1 (one) important activity you are unable or have difficulty performing as a result of your pain/symptoms. [Circle number below]:

_____ (ex. Stairs, reaching overhead) 0 1 2 3 4 5 6 7 8 9 10

No pain Worst pain Imaginable

What is your goal for therapy at this time?_____

Patient Signature_____ **Date:**_____

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PHYSICAL THERAPY

Medication List for:
Date:

Please list all medications, including all prescriptions, over the counter medications, herbals, vitamins, minerals, and dietary supplements. Include the dosage, frequency and administration method for each medication.

Medication	Dosage	Frequency	Method of Administration
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:

Patient Signature: ______________________________ Date: ____________________