## Patient Information

(Please Print)

Date_____ Home Phone_____

Patient_____
Last First Middle

Mailing Address_____Street Address_____

City _____State_____Zip_____

Sex (circle) M F Birthdate_____SS#_____
If minor, parents name

Patient Employeed By_____
Business Address_____
Occupation_____Business Phone_____

Spouse's Name_____
Spouse's SS# _____Employed By_____
Business Address_____Business Phone_____

Who is responsible for this account?_____
Relation to Patient_____Resp. party's SS#_____

Do you have medical insurance? (circle) Y or N If Yes:
Name of insurance company_____
SS# of person covered by insurance_____
Group #_____Policy #

Is this a work related injury? (circle) Y or N If Yes:
Date of injury_____Name of W/C carrier

### Assignment of Insurance Benefits

*I hereby authorize payment of benefits otherwise payable to me up to the stated charges to the provider(s) of services for all bills included with this statement unless otherwise noted.*

*I understand I am financially responsible for an amount not payable or not covered by the plan.*
Subscriber's Signature_____
Date

In case of emergency, who should be contacted?_____
Phone number_____

***We will bill your insurance company and send you a bill upon receipt of their payment. If you would prefer to pay after each visit, please let us know.

**Arctic Physical Therapy Services, Inc.**
**813 Lower Mill Bay Rd.**
**Kodiak, AK 99615**
**P(907)486-4499 F(907)486-8211**
**Web: www.arcticphysicaltherapy.com**
**Email: arcticpt@gmail.com**

## Authorization for Treatment and Permission for Release of Records

I hereby authorize treatment for _____ (print your name) at Arctic Physical Therapy Services, Inc. as referred by _____ (referring provider's name).

O.k. to call work: Yes____No____ Leave detailed message Leave message with call back number only

## Release/Credit Agreement

I consent to the release and/or exchange of all patient information between Arctic Physical Therapy Services, Inc., the above named physician, and /or my payment source. I understand that the information obtained will be treated in a confidential manner and that this release is effective for one year from the date of my signature.

I understand that Arctic Physical Therapy Services, Inc. has agreed to extend me credit for physical or occupational therapy services based on either third party coverage or a self-pay basis. I also understand that Arctic Physical Therapy Services, Inc. will bill my insurance as a courtesy, and that I am ultimately responsible for the total bill and agree to pay in a timely fashion should the third party, for any reason, fail to pay for the services rendered.

All supplies must be paid in full at the time of dispensing. The only exception to this is for Workman's Compensation (upon approval of carrier if over $50.00) Some custom garments, braces, and TENS units may require a 50% deposit at the time of dispensing. Arctic Physical Therapy Services, Inc. will refund my deposit or amount paid to me when my insurance company pays for the supplies.

Arctic Physical Therapy Services, Inc. reserves the right to charge a fee of $25.00 for missed pre-scheduled appointments with no cancellation notice. A patient who repeatedly cancels or does not show for their appointments will not be able to schedule any further appointments for six months. Furthermore, regarding accounts that are not paid, any collection costs or collection agency fees will be added to the total balance due. Interest will accrue at the rate of 10% for unpaid accounts after 90 days from the date of service.

I have read and understand the above agreement: _____ _____

Signature of Patient or Guardian Date

I have received and reviewed the Notice of Privacy Practices from Arctic Physical Therapy Services, Inc.

_____ _____

Signature of Patient or Guardian Date

Tricare STANDARD dependents Only

As a Tricare client, I understand that I am responsible for the 20% cost-share and deductible. I understand that I am responsible for any supplies issued to me by Arctic Physical Therapy Services, Inc.

_____ _____

Signature of Patient or Guardian Date

# ARCTIC PHYSICAL THERAPY SERVICES

Welcome to *Arctic Physical Therapy*! We want to make your time spent in physical therapy as beneficial as possible. Please help us by completing this questionnaire prior to your first appointment. We encourage you to ask questions and give your therapists input throughout your course of treatment.

Name:_____ Date_____
Phone #_____ AGE/DOB_____

What is your occupation?_____

Reason for physical therapy treatment:_____

Date of injury/onset of symptoms:_____

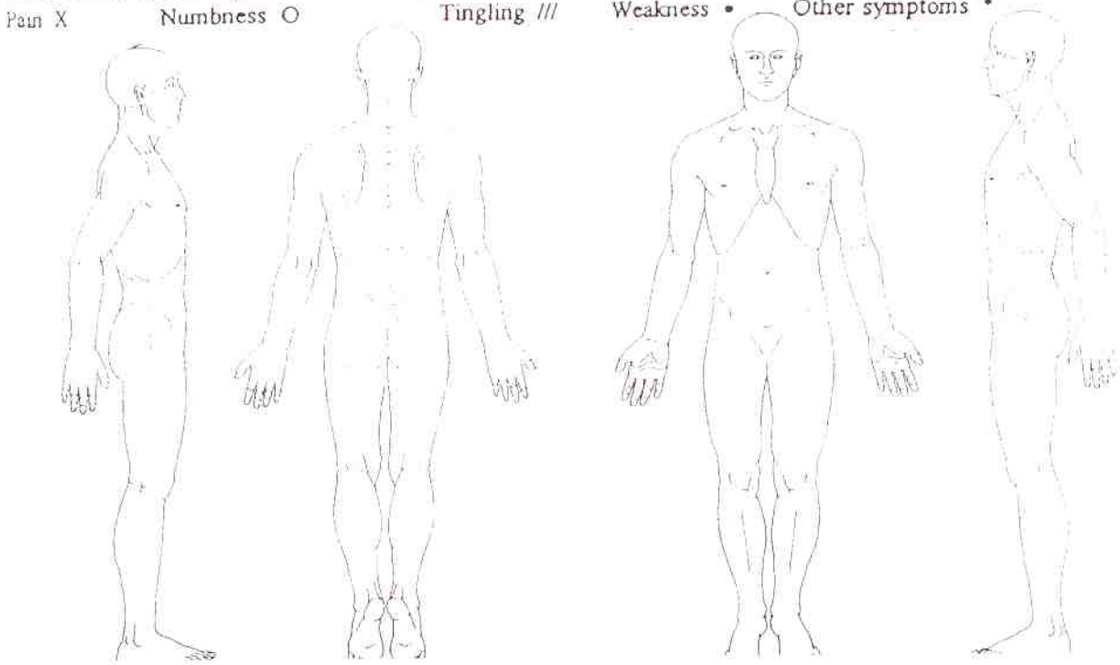
Symptoms

Please indicate whether you have experienced any of the following symptoms within the last 7 days and circle the level of severity at the present time:

| | None | | | | Moderate | | | | Severe |
|---|---|---|---|---|---|---|---|---|---|
| _____ Pain | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 10 |
| _____ Numbness | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 10 |
| _____ Tingling | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 10 |
| _____ Weakness | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 10 |
| _____ Dizzyness/Falling | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 10 |
| _____ Other: Please Specify _____ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 10 |

Please mark on the figures below any areas of:

Pain X Numbness O Tingling /// Weakness • Other symptoms •



Please list all medications you are presently taking and when you last took each. If you do not know the name, indicate what condition the medication is prescribed for:

| Medication/Purpose | Last Taken |
| --- | --- |
| | |
| | |
| | |
| | |
| | |

Drug Allergies/Latex Allergy:

_____

Surgeries/Dates: _____

_____

Previous Major Illness: _____

_____

Any medical conditions or physical limitations?

Current: _____

_____

Within the last year: _____

_____

List all doctor and other health care providers that you are presently seeing for treatment:

_____

Have you had physical therapy in the past? Yes No Where? _____

If yes, when and for what condition?

_____

What are your goals or expectations of physical therapy? (i.e. What would you like to be able to do that you can't do now)

_____

_____

_____

What activities are you having difficulty with as a result of this injury or dysfunction?

_____

_____