Florence Therapy & Wellness Inc.

5529 Old US Hwy 93, Florence, MT 59833

Patient Information:

Patient Name: Mr. Miss Ms. Mrs.

First:_____ Middle:_____ Last:_____

Date of Birth: _____ Sex: Male Female

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone Number: _____(_____)_____ Social Security Number: _____

Work Phone Number:(_____)_____ Marital Status: (circle one)

Cell Phone Number:(_____)_____ Single / Married / Divorced / Separated / Widow

Physicians Name:_____ Rx Date:_____

Referred to clinic by:_____

If patient is under 18, please fill in the following:

Parent/Guardian Name:_____ Parent /Guardian Name:_____

Relation to patient:_____ Relation to patient:_____

Home Phone Number: _____(_____)_____ Home Phone Number:_____(_____)_____

Work Phone Number:(_____)_____ Work Phone Number:(_____)_____

Cell Phone Number:(_____)_____ Cell Phone Number:(_____)_____

In Case of Emergency

Name of local friend or relative:

_____ Phone Number: (____)_____

Please complete ALL insurance information

Insurance Company:_____ ID #:_____

Primary Policyholder Name:_____ Policyholders DOB:_____

Patient relationship to Policy holder:_____

Guarantor:_____ Policyholder SSN#:_____

Secondary Insurance Company:_____ ID #:_____

Primary Policyholder Name:_____ Policyholders DOB:_____

Patient relationship to Policy holder:_____

Guarantor:_____ Policyholder SSN#:_____

Is this work related or a motor vehicle accident? Y / N

If yes, Insurance Company name:_____

Date of accident?_____ Attorney Name:_____

Employer:_____ Employer Phone Number :(__)_____

Claim #:_____

Financial Policy: I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above named insurance carrier(s). I permit a copy of this authorization to be used in place of the original. This authorization may be revoked in writing either by me or the above named carrier at any time. I certify that I represent only myself or individuals for who I am guardian and am not here on behalf of a third party. I authorize treatment by any or all providers and professional staff affiliated with Florence Therapy & Wellness Inc/Physical Therapy Solutions.

By signing below I confirm that I have read and understand the financial policy.

Patient/ Guardian Signature **Date**

_____ _____

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Notice of Privacy Practices Acknowledgments Tracking Information

Name of Patient: _____

Address: _____

_____

Signature of Patient: _____

Date: _____

Assignment of Insurance/Release of Information

I authorize treatment of the person named above and agree that I am financially responsible for all charges incurred through this office, regardless of insurance or third party liability and all proceeds of insurance are assigned to this office. I also request payments of government benefits either to myself or to third party who accept assignment. I authorize *Florence Therapy and Wellness, Inc./Physical Therapy Solutions* to provide health care information concerning my medical condition to my insurance company or third party payer. The above information is for the purpose of extending credit and is warrant to be true.

Patient/Responsible Party Signature:_____ Date:_____

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HEALTH HISTORY FORM

Do you or have you ever had:

High Blood Pressure	Yes	No	Difficulty Walking	Yes	No
Diabetes	Yes	No	Neurological Disease	Yes	No
Headaches	Yes	No	Paralysis	Yes	No
Muscular Disease	Yes	No	Stroke	Yes	No
Epilepsy	Yes	No	Head Injuries	Yes	No
Skull Fracture	Yes	No	Cooridination Issues	Yes	No
Neck Injuries	Yes	No	Change in Handwriting	Yes	No
Back Injuries	Yes	No	Dizziness	Yes	No
Drowsiness	Yes	No	Heart Disease	Yes	No
Generalized Weakness	Yes	No	Lung Disease	Yes	No
Frequent Infections	Yes	No	Bleeding Problems	Yes	No
Bone Disease	Yes	No	Arthritis	Yes	No
Broken Bones	Yes	No	Cancer	Yes	No
Joint Problems	Yes	No	M.S.	Yes	No

	Operations	Date	Doctor
1			
2			
3			

Allergies:

_____

_____

_____

Medications you have been taking:

_____

_____

_____

Present Problems:

_____

_____

_____

Patient Signature: _____ Date: _____

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

To:_____

Doctor we are requesting patient information from

PATIENT INFORMATION (Please Print):

Specify type of records:_____

Patient Name:_____ Date of Birth:_____

Phone:_____

RELEASE MY MEDICAL RECORDS TO:

Florence Therapy & Wellness, Inc.
Fax: (406) 273-4341

Print Your Name:_____

Patient/Guardian Signature:_____ Date:_____

Mara Arlington, M.P.T, D.P.T. • Rachel Sherba, M.P.T. • Chris Phipps, O.T.R.
FTW Phone: (406) 273-4246 •PTS Phone: (406) 728-7888 • Fax: (406) 273-4341

Medical Information Release Form

(HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____

Appointment Reminder Consent

Patient Name (please print):

_____

Complete this form and sign below to give your permission for Florence Therapy and Wellness to provide automatic appointment reminder service by email or by cell phone text message.

Step One: Select One Option Below

☐ Florence Therapy and Wellness may send email messages to confirm my upcoming appointments.
Email address:

☐ Florence Therapy and Wellness may send cell phone text messages to confirm my upcoming appointments.
Cell Phone number:
I recognize that normal text messaging rates may apply.

Step Two: If you would like text messages instead of email reminders, please indicate your Cell Phone Carrier.

We cannot set your account up to send email text message reminders without knowing your cell phone carrier. Please indicate your carrier below, if you would like text message reminders:

- ☐ ALLTel
- ☐ AT&T
- ☐ Boost Mobile
- ☐ Cingular
- ☐ Cricket Wireless
- ☐ Metrocall
- ☐ MetroPCS
- ☐ Nextel
- ☐ Qwest
- ☐ Sprint PCS
- ☐ T Mobile
- ☐ US Cellular
- ☐ Verizon
- ☐ Virgin Mobile

_____
Signature of Patient or Guardian

_____
Date

Are You at a Healthy Weight?

Body Mass Index, (BMI) is a measurement used to estimate body fat percentage in relationship to your height and weight. When calculated, your BMI will help you determine your weight status classified as either underweight, healthy, overweight, obese and extremely obese. As your BMI number increases so does your risk for several health conditions or diseases such as diabetes, high blood pressure, heart disease and some cancers.

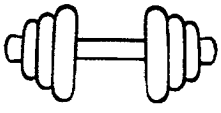
If your calculated BMI is 25 or higher:

You are classified as overweight or obese and losing weight may be very important to help lower your risk of many diseases. Losing as little as 5 to 10% of your current weight can have positive effects on your overall health. Choose sensible ways to lose weight by avoiding crash diets, limiting your fat intake and aiming for at least 30-40 minutes of physical activity 5-7 times a week.

If your calculated BMI is less than 18.5:

You are classified as being underweight which may indicate malnutrition. This can slow down wound healing and recovery time from illness. This also puts you at risk for heart attack or infection as well as loss of fertility. Consult your doctor or a dietician to assess your caloric intake and nutritional supplements. Begin a regular exercise routine involving strength training and weight bearing activities to help build muscle.

Please see reverse side to calculate your BMI. Talk with your doctor or health care professional with any questions or concerns regarding your weight.



Body Mass Index Chart