Arapahoe Peak Physical Therapy

Bergen Park Physical Therapy

Welcome

Welcome to Arapahoe Peak and Bergen Park Physical Therapy! You are very important to us, and we have reserved this appointment especially for you. In order for you to obtain optimal benefits from your treatment program, it is essential that you attend each and every scheduled visit and follow a few simple guidelines. Your first appointment will last 45-60 minutes. Follow up visits will last 45 minutes. Please arrive 15 minutes prior to your first scheduled appointment time to complete the paperwork required.

We are here as part of your rehabilitation team to teach you to manage your injury. Our policies exist to promote the continuity of care and recovery process, to reduce the length of disability, to reduce the overall cost of each case and to allow for optimal utilization of staff time.

ALCOHOL	Alcohol and non-prescribed substances are not allowed on the premises. If you have been drinking alcohol or using non-prescription drugs before your treatments, you will not be allowed to participate in therapy.
ATTIRE	Comfortable, loose fitting clothes (such as shorts, t-shirts and sweats) should be worn with tennis shoes.
VISITORS	Due to space limitations and for safety reasons, children and other family members or friends are not allowed in the treatment areas. Children left in the waiting area MUST be accompanied by an adult. Our staff cannot supervise children left in the waiting area. The Buchanan Recreation Center offers child care services, if needed.
INSURANCE	We are happy to verify your insurance coverage prior to you treatment. However, it remains the patient's responsibility to know which services your insurance company covers. Initial:_____
ATTENDANCE	All cancellations should be made as soon as possible in advance of your scheduled appointments, preferably no less than 24 hours prior to the appointment. If you fail to attend a scheduled appointment (and did not call to cancel or reschedule) you will be considered a “no-show”. Reasonable attempts will be made to accommodate you based on availability, however, this cannot be guaranteed. You may be charged a $45 no-show fee, so we encourage you to attend all scheduled appointments or give adequate notice to cancel the appointment to avoid this charge. Initial:_____ If you “no-show” for two therapy sessions or have a total of 3 canceled therapy appointments, we reserve the right to discharge you from therapy. A phone call or formal letter will be sent to you doctor, care manager, and/or employer/insurance carrier. No further appointments will be scheduled without a new referral from your physician. The frequency of your appointments is determined by your physician and therapist based upon your injury, but is usually 2-3 times a week. Appointments should be scheduled at least one week in advance. It is your responsibility to reschedule a missed appointment and you are encouraged to do this as soon as possible.

Arapahoe Peak Physical Therapy

Bergen Park Physical Therapy

Registration Form

Patient Name: _____
Last First (legal) Nickname

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: Home (_____)_____ Work: (_____)_____ Cell: (_____)_____

Birth Date: _____ Sex: Male Female

E-mail: _____

If Patient is a minor:
Mother's Name: _____ Contact Phone: _____

Father's Name: _____ Contact Phone: _____

Insurance Information:
Responsible Party/Insurance Policy Holder: _____

SS#_____ Date of Birth_____

Address/Phone (if different than listed above) _____

Primary Insurer name: _____ID#:_____

Secondary Insurer name:_____ID#:_____
Please give current insurance card(s) to the receptionist to copy for your chart.

We outsource our billing. Any account balance(s) should be paid by 30 days from the date of the itemized statement. If deemed necessary, Arapahoe Peak and Bergen Park Physical Therapy reserves the right to forward the account balance(s) 60 days following the itemized statement to our collections agency. Any and all phone numbers and e-mails provided to our office; be it residential, employment or wireless, are authorized methods of communication by our office or by our collection agency in regards to any outstanding collection balances. Should collections be necessary, any payment make to the collection agency via an electronic payment (such as check over the phone or credit card) will incur a convenience fee. A convenience fee is a fee incidental to your payment obligation. Should litigation be necessary to collect an amount owed, the responsible party agrees to pay all costs of collection including, but not limited to collection fees (up to, but not more than 25%), attorney fees, interest at the rate of 18%, plus court costs.

_____ _____
Signature Date

Arapahoe Peak Physical Therapy

Bergen Park Physical Therapy

Medical History

Name:_____ Date:_____ Age: _____

Date of Birth:_____ Height:_____ Weight:_____ Dominant Hand: R L

Allergies: Please list all known allergies (food, medications, lotions, etc.)

_____

_____

_____

Medications: List all medications, including over-the-counter medications that you are taking:

Name:_____ Purpose:_____
Name:_____ Purpose:_____
Name:_____ Purpose:_____
Name:_____ Purpose:_____

Have you had any of the following? Please circle Yes or No and give descriptions/dates of experiences.

Y N Allergies	Y N Coronary Artery Disease	Y N Hepatitis A B C
Y N Anemia	Y N Diabetes	Y N High Blood Pressure
Y N Angina	Y N Elevated Cholesterol	Y N Lung Disease
Y N Arthritis	Y N Elevated Triglyceride	Y N Osteoporosis
Y N Asthma	Y N Epilepsy	Y N Seizures
Y N Blood Disorders	Y N Fever (Rheumatic/Scarlet)	Y N Stroke
Y N Bronchitis	Y N Fever (Recent)	Y N Surgical Procedures
Y N Cancer	Y N Congestive Heart Failure	Y N Tuberculosis
Y N Circulatory Problems	Y N Recent/unexplained weight loss	

Explanation/Dates:_____
Do you currently have or have had any other serious illnesses or chronic problems? (If yes, please explain):
_____
Are you pregnant? No Yes If yes, what trimester?_____
Do you smoke? No Yes Quit (year)_____
Do you exercise regularly? No Yes If yes, how often?_____
What is your goal for physical or occupational therapy?
_____
The above information is accurate, and to the best of my knowledge, represents my present health. I understand this information is confidential and is provided for my safety as a participant of Arapahoe Peak and Bergen Park Physical Therapy.

Arapahoe Peak Physical Therapy

Bergen Park Physical Therapy

Phone Message Consent

In order to protect your privacy, we have developed a policy on leaving medical care messages.

- We will NOT leave messages with anyone except the patient or legal guardian.
- We will NOT leave any confidential information on an answering machine.
- We will NOT leave any messages on a voice mail.

Unless, we have your written permission to do so.

Please read below and consider carefully whom you authorize to have access to protected information regarding your care.

I,_____, give Arapahoe Peak and Bergen Park Physical Therapy my permission to speak with and/or leave phone messages regarding my medical care and/or billing information with the following. I fully understand that this consent will remain valid until revoked in writing.

Home #: _____ Initials: _____

Cell #: _____ Initials: _____

Work/Voice Mail: _____ Initials: _____

Spouse/Guardian: _____ Initials: _____

Other: _____ Initials: _____

Emergency Contact:

Name of Relative not living with you: _____

Relationship: _____ Phone: _____

How were you referred to us? _____

_____ _____

Signature Date

Arapahoe Peak Physical Therapy

Bergen Park Physical Therapy

Payment for Services

We accept cash and check for payment of services rendered. Should you need other arrangements, please let us know.

Patient Consent Form

I, the undersigned, hereby consent to the following treatment:

- Administration and performance of all treatments
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnosis procedures/tests

I fully understand that this is given in advance of any specific diagnosis or treatment.
I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.
I, the undersigned, acknowledge that Arapahoe Peak and Bergen Park Physical Therapy will use and disclose my information for the purposes of treatment, payment, and health care operations as described in the Notice of Privacy Practices.
A photocopy of this consent shall be considered as valid as the original.

Medicare Patients Only: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Arapahoe Peak and Bergen Park Physical Therapy. **Patient Initial_____**

HIPAA: I acknowledge that I have been given the Arapahoe Peak and Bergen Park Physical Therapy Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official.
Patient Initial_____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____
Signature Date

_____
Print Name