Arctic Physical Therapy Services

813 Lower Mill Bay Rd.
Kodiak, AK 99615
P: (907) 486-4499
F: (907) 486-8211

Authorization for Treatment and Permission for Release of Records

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

Release/Credit Agreement

I agree to the release and/or exchange of all patient information between Arctic Physical Therapy Services, the above-named physician, and my payment source. I understand 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. _____ (initials)

I understand that Arctic Physical Therapy Services has agreed to extend me credit for my physical therapy services based on either third-party coverage or a self-pay basis.
I also understand the APTS 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 my insurance, for any reason, fail to pay for services rendered. _____ (initials)

Any/all supplies must be paid in full at 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. APTS will refund my deposit or amount paid to me when my insurance company pays for the supplies. _____ (initials)

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

Cancellation Policy

Arctic Physical Therapy Services reserves the right to charge a fee of $40.00 for missed appointments and last-minute cancellations (under a 24-hour notice). Arriving to appointments over 15 minutes late will be considered a missed appointment and will result in a charge of $40.00. A patient who repeatedly cancels or does not show for their appointments will not be able to schedule any further appointments without paying the cancellation/no-show fee. Continued abuse of this policy may lead to discontinuance of care. _____ (initials)

I have read and understand the above agreement:

_____ _____
(Signature of Patient or Guardian) Date

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Patient Information

(Please Print)

Patient Name: _____ Date: _____
Last First Middle

Mailing Address: _____ Street Address: _____
City: _____ State: _____ Zip: _____

Sex: (circle) Male Female Date of Birth: _____ SS#: _____

Contact information: Home #: _____ Cell #: _____
Email: _____ Work#: _____
Preferred form of contact: (please circle) Home Cell Work Email

Emergency Contact: _____ Phone#: _____

If patient is a minor, please provide parent/guardian information:
Name: _____ Date of Birth: _____
Relation to patient: _____

Patient Employed By: _____ Occupation: _____

Business Address: _____ Phone: _____

Insurance Information

Name of person responsible for this account (if other than Self): _____
Relation to Patient: _____ Responsible Party SS#: _____

Do you have primary medical insurance coverage? (circle) Yes or No
If Yes, please provide the name of the insurance company: _____
Policy/ID #: _____ Group #: _____
SS# of policy holder: _____

Do you have secondary medical insurance coverage? (circle) Yes or No
If Yes, please provide the name of the insurance company: _____
Policy/ID #: _____ Group #: _____
SS# of policy holder: _____

Is this a work-related injury? (circle) Yes or No
If Yes, please provide the name of the Workmen's Comp. carrier: _____
Claim #: _____ Date of Injury: _____

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 any amount not payable or not covered by my insurance plan.

Signature of Patient or Guardian: _____ **Date**: _____

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Medical History

Patient Name: _____ Date: _____
Last First Middle

Please list all medications you are presently taking; the condition being treated and when you last took each. If you don't know the name, just indicate what condition the medication is prescribed for:

Medication/Purpose	Last Taken
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies: (medications/latex) _____

How and when did this injury/exacerbation occur? _____

_____

Have you had surgery for the present condition? Yes / No If Yes, date: _____

Have you received previous treatment for this condition? Yes / No If Yes, date: _____

If yes, please explain type of treatment: _____

Please list all health care providers that you are presently seeing for treatment: _____

_____

Have you had any falls this past year? Yes / No If Yes, how many? _____

Is there any other information regarding your medical history that we should know about? (i.e. other surgeries/procedures/major illnesses/medical conditions?) _____

_____

_____

Signature of Patient or Guardian: _____ Date: _____

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Patient Name: _____ Date: _____
Last First Middle

What are your goals or expectations for physical therapy at this time? (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? _____
_____
_____

To help us understand your symptoms, please circle all that apply:
My pain is worse: constant / in the morning / during the day / at night / with activity / during rest

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
____ Dizziness	1	2	3	4	5	6	7	8	9	10

____ Other: Please Specify: _____

Please mark on the figures below any areas in which you experience the following symptoms:
X -- Pain/ Tenderness ↑ **or** ↓ -- Radiating Pain /// -- Numbness/Tingling **ooo** – Weakness