Alternative HealthCare Solutions

Patient Information and Medical History form

This information will be handled with the strictest confidence in accordance with HIPAA regulations.

The following information will assist Alternative HealthCare Solutions to better serve you in several ways.

- It will help use to better understand your unique health history.
- It will help us to correctly record and report our findings to your Doctor.
- It will assist us in the billing process by assuring fast accurate reporting to the insurance company.

How did you hear about Alternative HealthCare Solutions?_____
_____

Diagnosis or problem for which you are seeking help. _____
Was this due to (circle one) **an accident** or **job related** Is an attorney involved in this case? YES NO
Your Name_____Date _____
Address_____Home phone #_____
_____Work phone #_____
Soc. Sec #_____/_____/_____Height_____ Weight _____ Cell phone # _____
Date of Birth_____Age_____ Sex M F E-MAIL ___ _____
May we have your permission to call you and leave a message on your phone / answering machine? Yes No
Parent/ Responsible party_____ BWC claim? Y N
Referring Physician_____BWC claim #_____
Address_____Emergency contact:_____
_____ Dr. phone #_____Specialty_____

INSURANCE INFORMATION

Primary insurance_____ ID #_____
Address_____ Group #_____
_____Claim #_____
Phone #_____

Secondary Insurance_____ ID #_____
Address_____ Claim #_____
_____ Phone #_____

History of Your Health

Have you ever been to a therapist before? Yes No
If yes to the above, please give brief details_____
_____
_____

Do you have a personal history of any of the following?

Cancer _____Yes No
Heart disease _____Yes No
Pacemaker _____Yes No
Lung Disease _____Yes No
High Blood Pressure ___Yes No
Diabetes _____Yes No
Poor circulation _____Yes No
Metal Implants _____Yes No
Leaking urine with coughing, sneezing, laughing, jumping or lifting. Yes No

Major surgeries and Dates_____
_____
_____

ANY OTHER MEDICAL PROBLEMS: _____
_____
_____
_____

Current Medications: _____
_____
_____

Allergies: _____
_____

Is there a chance you are pregnant? Yes No

Please circle your current level of discomfort:
No pain 1 2 3 4 5 6 7 8 9 10 **Shoot me!!!!**

Please circle your current level of emotional well being:
Fantastic 1 2 3 4 5 6 7 8 9 10 **Horrible!!!!**

If I could change one thing about my current situation it would be:_____
_____
_____

As soon as I get over this pain I'm going to:_____
_____

Is there anything else that you feel would be helpful to let me know before starting?_____
_____
_____
_____

BILLING POLICY:

1. I understand that it is the responsibility of the patient to check with their insurance company as to allowed coverage of Physical Therapy sessions at Alternative HealthCare Solutions
2. I understand that Alternative HealthCare Solutions does *not* accept UCR on *every insurance plan* and that it is up to the patient to clarify specific policies with their own insurance company.
3. I understand that I am responsible for payment of my bills from Alternative HealthCare Solutions and that interest and collection costs will be added to the bill if bills become over due or delinquent.

I fully understand and will comply with the above conditions as a precondition to beginning evaluation and treatment with Alternative HealthCare Solutions.
Signature_____**Date**_____

CANCELLATION POLICY:

- Alternative HealthCare Solutions does not over book / double book our appointments.
- Alternative HealthCare Solutions is unique in the amount time we reserve for each patient.
- Alternative HealthCare Solutions schedules each patient, one on one for a full hour if needed.
- Missed appointments leave needless gaps in the schedule and deprive waiting patients.
- Habitual no shows or last minute canceling shows a lack of commitment to achieving your goals.

$50.00 will be assessed for each appointment that is a **no-show or cancelled less than 24 hours** from the scheduled appointment**.** **This fee will not be charged to the insurance company, it will be collected from you.**

PLEASE STRIVE TO ATTEND ALL APPOINTMENTS AND DO NOT SCHEDULE UNLESS YOU ARE VERY SURE OF YOUR ABILITY TO MAKE THE APPOINTMENT. ALL CANCELLATIONS MUST BE MADE AT LEAST 24 HOURS AHEAD TO AVOID THE $50.00 CHARGE.

I fully understand and will comply with the above conditions as a precondition to beginning evaluation and treatment with Alternative HealthCare Solutions
Signature _____**Date**_____