AVENUES THERAPY CLINIC PATIENTS
PLEASE READ OVER AND SIGN

While on the premises of Avenues Therapy Clinic, each patient is responsible for his or her own belongings. Avenues Therapy Clinic waives all liability for personal items left unattended.

Payment Policy

As a courtesy to all our patients, we bill your insurance company. It is, however, the patient's responsibility to know and understand what their insurance company does and does not cover. Avenues Therapy Clinic does not accept the responsibility for the accuracy of the information provided to us by you or your insurance company. In any event, the entire bill is the patient's responsibility. Any overpayment will be promptly refunded.

Insurance and Billing

As a convenience to you, Avenues Therapy Clinic will bill your health insurance company for your physical therapy or occupational therapy. Please take a moment to review your insurance policy. Your policy may only pay up to a certain dollar amount or percentage. Also, your policy may only allow a certain number of visits and/or may require pre-authorization for these appointments. Every policy is different so for your benefit, please take the time to review yours. For our records, please keep us updated on any changes such as your billing address, phone number or insurance coverage.

HMO or PPO Members: Co-pays are due at the time of each visit

Our contract with your insurance company dictates that we collect the specified co-payment at the time of service.

We accept personal checks, VISA, MasterCard, American Express and Discover

there is a returned check processing fee of $25.00 per occurrence

Private Insurance: Deductible and co--insurance amounts are billed monthly once your insurance company has processed your claim. Payment in full is due within 30 days of the statement date. Those accounts not paid in full after the due date may be placed with a collection agency. The patient/responsible party may be responsible for 100% of the collection costs, reasonable attorney fees, and other costs that may be incurred to enforced collection of any amounts outstanding.

AUTHORIZAION TO PAY: I hereby authorize payment directly to Avenues Therapy Clinic for any medical benefits otherwise payable to me for services. I understand that I am financially responsible for the charges not covered by insurance.

I, _____ have read and understand the payment policies.

Patient Signature:_____ Date:_____

Cancellation Notice

At Avenues Therapy Clinic, our priority is quality patient care. We are very dedicated to you the client and are determined about results. In order for us to better assist you in maximizing your desired outcome, compliance to your scheduled clinic appointment times are strongly encouraged. Our time is also very valuable to assisting other clients. For these reasons, a 24 hour notice is appreciated. If 24 hour notice of cancellation is not received, a $25.00 fee may be charged to you.

Thank you,

Avenues Therapy Clinic

Patient Signature:_____ Date:_____

Workers Safety and Compensation

If you are an injured workers compensation patient, please be aware of the following

- Workers Compensation follows your therapy
- Your therapy appointments are important, so please keep cancelations to a minimum
- All cancellations/no shows are documented for workers compensation
- YOU WILL BE RESPONSIBLE FOR ANY BALANCE WORKERS COMPENSATION DOES NOT PAY

Avenues Therapy Clinic
Patient Consent Form

Patient Copy

By signing this consent form, I am giving permission to **Avenues Therapy Clinic** to use and disclose my protected health information for the purpose of my treatment (We may use or disclose your health information to a physician or other healthcare provider providing treatment to you), obtaining payment (We may use and disclose your health information to obtain payment for services we provide to you), and the organization's health care operations (We may use and disclose your health information in connection with our operations which may include quality assessment and improvement activities, reviewing the competence of qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities).

You have the right to allow family, friends, persons involved in your care, as well marketing-related services. Anyone of your choice for any purpose can be authorized to obtain your protected health information. Each of these will require your written authorization. If you give us and authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect. Unless you give us an written authorization, we cannot use to disclose your health information for any reason except those described by this notice.

You always have a right to request that our organization restrict how we use and disclose your protected health information for the purposes of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we will be bound by our agreement to comply with such restrictions. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

We may use or disclose your health information when we are required to do so by law. This could include abuse or neglect (If we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes, we may disclose your health information to the extent necessary to avert a serious through to your health or safety or the health or safety of others), or for national security purposes (We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counter intelligence, and other nation security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

You have the right to look at or get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by contacting Avenues Therapy Clinic. There will be a reasonable cost-based fee for expenses of this request. These fees are posted at the front desk of the clinic. Any questions regarding this request can be answered at the time of request.

Our organization's Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to receive and review it if you would like before you sign this consent; and we encourage you to read it in full.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have use communicate with you by alternative means or at alternative locations, you may contact Avenues Therapy Clinic in any format you deem fit, or you may submit a written request to the U.S. Department of Health and Human Services, which we can provide an address for if requested.
We support your right to the privacy of your health information.

Avenues Therapy Clinic
4000 Central Ave, Suite 3
307-634-0298
avenuestherapyclinic@yahoo.com

Avenues Therapy Clinic
Patient Consent Form

Clinic Copy

I understand that I am required to sign this consent, subject to certain exceptions, in conjunction with the consent form given to me as a condition of receiving treatment from Avenues Therapy Clinic.

Signed:_____ Date:_____
Signature of Patient/Legal Representative

MINORS:
I, the undersigned or designated representative for the patient, do hereby agree and give my consent for Avenues Therapy Clinic to furnish any and all medical care and treatment to _____ considered necessary and proper in diagnosing and /or treating his/her physical condition. I understand that no guarantees or promises are made concerning the outcome of treatment.

_____ _____
Patient/Guardian/Responsible Party Date

Name: _____ Date: _____

Medical History

Treatment side:

- ☐ N/A
- ☐ Left
- ☐ Right

Injury/Onset Date/Change of Status Date _____

Occupation: _____

Currently Working:

- ☐ No
- ☐ Yes

If Yes, Are you under any restrictions :

_____

_____

_____

Surgery Performed:

- ☐ No
- ☐ Yes

Surgery Date: _____ Type: _____

Prior Hospitalization:

- ☐ No
- ☐ Yes

History of Present Condition/ Mechanism of Injury: _____

_____

_____

Primary concern/Chief complaint: _____

_____

_____

Worse With:

- ☐ Bending
- ☐ Sitting
- ☐ Turning
- ☐ Rising
- ☐ Standing
- ☐ Lying
- ☐ Walking
- ☐ In the A.M.
- ☐ As day goes by
- ☐ In The P.M.
- ☐ When Still
- ☐ On the move
- ☐ Other

_____

_____

_____

Name: _____

Better With:

- ☐ Bending
- ☐ Sitting
- ☐ Turning
- ☐ Rising
- ☐ Standing
- ☐ Lying
- ☐ Walking
- ☐ In the A.M.
- ☐ As day goes by
- ☐ In the P.M.
- ☐ When still
- ☐ On the move
- ☐ Other

_____

_____

_____

Previous History of Similar Symptoms:

- ☐ No
- ☐ Yes

General Health:

- ☐ Good
- ☐ Fair
- ☐ Poor

Home Health Care:

- ☐ No
- ☐ Yes

If yes, please give discharge date and facility/company name:

_____

_____

History of Falls:

- ☐ No
- ☐ Yes

If yes, Date of last fall:

_____

Medical History:

- ☐ Alzheimer's
- ☐ Cardiovascular Disease
- ☐ Cauda Equina Syndrome
- ☐ Cerebral Vascular Accident (Stroke)
- ☐ Current Infection
- ☐ Depression
- ☐ Diabetes Mellitus Type 1
- ☐ Diabetes Mellitus Type 2
- ☐ Fibromyalgia
- ☐ Fracture or Suspected Fracture
- ☐ High Blood Pressure
- ☐ History of Cancer
- ☐ Huntington's
- ☐ Immunosuppression
- ☐ Lupus
- ☐ Muscular Dystrophy
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Parkinson's
- ☐ Rheumatoid Arthritis
- ☐ Traumatic Brain Injury
- ☐ Other

_____

_____

_____

Allergies:

- ☐ No
- ☐ Yes

If yes, please specify to what:

_____

Name: _____

Diagnostic Testing:

- ☐ X-Ray
- ☐ EMG
- ☐ MRI
- ☐ CT Scan
- ☐ Blood Tests
- ☐ Other _____ _____

Other Surgeries:

- ☐ No
- ☐ Yes

If yes, please specify:

_____

_____

Height: _____

Weight: _____

Unexplained Weight Loss:

- ☐ N/A
- ☐ No
- ☐ Yes

Current Medications with Prescription (Please list below or provide us with your list to copy) :

- ☐ No
- ☐ Yes

Medication Name and Dosage:

_____

_____

_____

Over the Counter:

- ☐ No
- ☐ Yes
- ☐ Advil, Ibuprofen, Tylenol
- ☐ Herbals
- ☐ Vitamin/ Mineral/Dietary Supplements
- ☐ Not currently taking any medications

Have you had other PT treatments for this problem :

- ☐ No
- ☐ Yes
- ☐ Chiropractic

Name: _____

Home Layout (check all that apply):

- ☐ 1 Story
- ☐ 2 Story
- ☐ Steps
- ☐ Shower Stall
- ☐ Combo Bathtub/Shower
- ☐ Wheel Chair Accessible

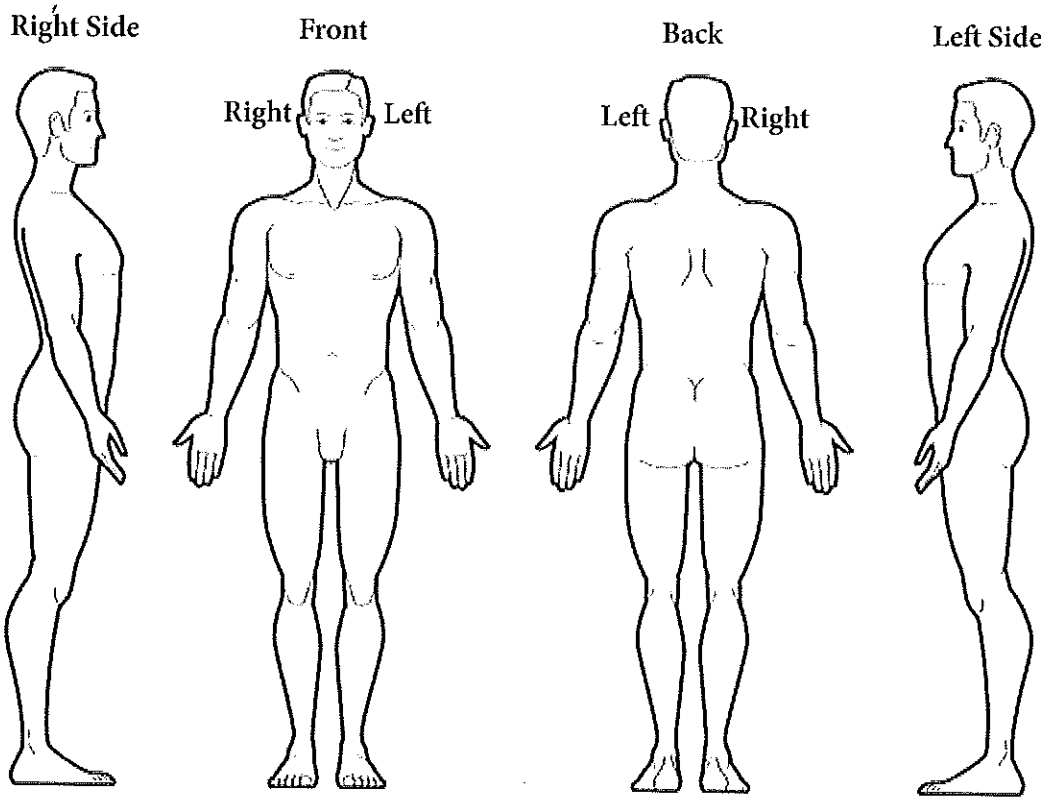
Do You Use (Check all that apply):

- ☐ Tub Bench
- ☐ Shower Chair
- ☐ Grab Bars
- ☐ Bedside Commode
- ☐ Raised Toilet Seat
- ☐ Standard Walker
- ☐ Rolling Walker
- ☐ Hemi Walker
- ☐ Quad Cane
- ☐ Straight Cane
- ☐ Wheelchair

Avenues
Therapy Clinic

NAME: _____ DATE: _____

MARK YOUR AREAS OF PAIN:



What activities would like to be able to perform with less pain or difficulty?

1. _____
2. _____
3. _____