avanti therapy

PATIENT INFORMATION

Name: Last_____First_____MI_____Pronouns_____

Email Address: _____

Date of Birth: Month _____ Day_____ Year _____

Physical Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Billing Address (if different): _____

City: _____ **State:**_____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____

Emergency Contact: Name _____ Phone _____

GENERAL INFORMATION

Referring Doctor _____ **Family Doctor** _____

Description of Problem _____

Have you had surgery? Yes ☐ **No** ☐ **If yes when?** _____ **Surgeon:** _____

INSURANCE INFORMATION

Name of Policy Holder: _____

Date of Birth: Month _____ Day _____Year _____

Relationship to Patient: _____ **Employer:** _____

Name of Insurance: _____ **Insurance Phone:** _____

ID Number: _____ **Group Number:** _____

Secondary Insurance: _____ **ID Number:** _____

Agreement for Payment of Services:

We believe that prompt payment for our services is part of the contract that exists between practitioner and client. We will provide you with quality therapeutic services, and you agree to pay us promptly for our services.

I understand that I am responsible for all charges for services provided for me, regardless of insurance coverage, and that payment is due at the time services are rendered unless my physician has a contract with my insurance company to bill the insurance company first.

I agree to pay any co-payments or deductible amounts for which I am responsible under my insurance policy at the time of service. I agree to pay for any services that I have received which are subsequently determined to be "not covered" by my insurance; including, but not limited to deductible and co-insurance amounts. I understand that my credit card number will be kept on file for any applicable fees to be charged in the event of non-payment. I understand that ***Avanti Therapy, LLC*** *bills my insurance company as a courtesy and that I must be proactive within the process assuring that payment is received in a timely fashion. All bills for services are due upon receipt, and any balance that remains unpaid for 30 days or longer will be charged a $75 late fee. If my account is referred to a collection agency or attorney, I understand that I will be liable for the collection fees, attorney's fees, and any court costs, in addition to my outstanding balance. I authorize the release of medical information necessary to process my claim if such information is requested by my insurance company. I hereby assign payment directly to* ***Avanti Therapy, LLC*** *to Payer Groups. The basic benefits as well as major medical benefits herein specified and otherwise payable to me, but not to exceed the regular charges for this treatment period.*

Signature: _____ **Date:** _____

5353 MANHATTAN CIRCLE, SUITE 103 BOULDER, CO 80303
PH: (303) 543-1201
FX: (303) 543-1206
info@avantitherapy.com
www.avantitherapy.com

avanti therapy

PLEASE READ AND CHOOSE AN OPTION BELOW – IF YOU DO NOT CHOOSE AN OPTION, WE WILL ASSUME THAT YOU DO NOT WANT REMINDER NOTIFICATIONS FROM AVANTI THERAPY.

*As a **courtesy**, we have an automated notification system that will send out reminder phone calls, text messages, or emails, prior to your appointment.*

By providing us with your contact information, you are giving us permission to send you reminder messages for appointments as well as periodic relevant, clinical information. If at any time you would like to opt out of this service, please notify our front desk staff. PLEASE UNDERSTAND that these calls/texts/emails are AUTOMATED and may come with less than 48 hours until your appointment – THESE REMINDERS ARE A COURTESY. THE TIMING OF THESE CALLS WILL NOT EXCUSE THE $75 LATE CANCELLATION FEE THAT WILL INCUR if you need to cancel with less than 48 hours' notice. ***PLEASE NOTE THAT WE DO NOT ACCEPT CANCELLATIONS VIA EMAIL..***
Furthermore, as stated on the Avanti Therapy Policies, Monday cancellations ***MUST be received by 12pm the preceding Friday.***

I WOULD LIKE MY REMINDERS TO BE SENT VIA :

☐ Phone Call at this number: _____

☐ Text Message at this number: _____

☐ Email at this address: _____

☐ I do not want reminder notifications

PLEASE READ THOROUGHLY AND SIGN THAT YOU UNDERSTAND THE ABOVE:

Signature: _____

5353 MANHATTAN CIRCLE, SUITE 103 BOULDER, CO 80303
PH: (303) 543-1201
FX: (303) 543-1206
info@avantitherapy.com
www.avantitherapy.com

avanti therapy

Name: _____ *Date:* _____

Occupation: _____

Please describe the reason for your visit:

What increases your discomfort?

What decreases your discomfort (include all previous or current treatments)?

Have you undergone diagnostic testing for your current problem (x-rays, MRI, etc.)?

Please circle the number that corresponds to your current pain:

0	1	2	3	4	5	6	7	8	9	10
None		Mild		Nagging		Miserable		Intense		Unbearable

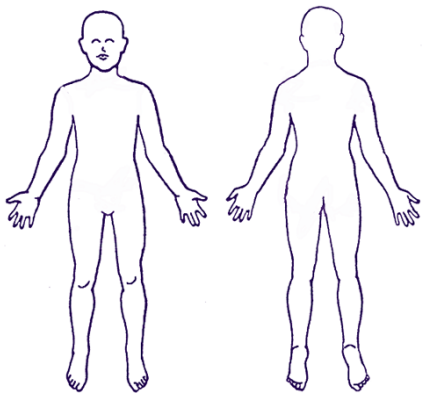
How would you describe your pain?

( ) Sharp ( ) Dull ( ) Burning ( ) Aching

*( ) Tingling ( ) Constant ( ) Intermittent ( ) Stabbing ( ) Other:*_____

Please mark the areas of your symptoms as follows:

Circle - areas of pain
XX – areas of numbness/tingling
//// - areas of muscle tightness/soreness



Do you exercise regularly? If so, please provide details of type and frequency of your exercise and physical activities:

Please list the medications and or supplements, including dosage, which you are taking:

5353 MANHATTAN CIRCLE, SUITE 103 BOULDER, CO 80303
PH: (303) 543-1201
FX: (303) 543-1206
info@avantitherapy.com
www.avantitherapy.com

avanti therapy

Name _____ **Date** _____

Please check the appropriate box if you or an immediate family member (parent, sibling, child) have ever been diagnosed with any of the following:

YOU		FAMILY MEMBER
	Allergies (Including food, adhesives, medications)	
	Anxiety / panic attacks	
	Arthritis	
	Breathing Problems including asthma	
	Cancer (If yes, what kind?)	
	Chemical dependency (alcohol or drugs)	
	Circulation problems	
	Depression	
	Diabetes	
	Eating disorder	
	Headaches	
	Heart problems including chest pain	
	High blood pressure	
	Hepatitis	
	High cholesterol	
	Kidney disease	
	Multiple sclerosis	
	Osteoporosis	
	Seizures	
	Stroke	
	Tuberculosis	
	Other:	

HAVE YOU RECENTLY EXERIENCED:

Unusual fatigue	*YES*	*NO*
Weight loss / gain	*YES*	*NO*
Nausea / vomiting	*YES*	*NO*
Loss of appetite	*YES*	*NO*
Difficulty swallowing	*YES*	*NO*
Night sweats	*YES*	*NO*
Fever / chills	*YES*	*NO*
Numbness or tingling	*YES*	*NO*
Dizziness or fainting	*YES*	*NO*
Changes in bowel or bladder	*YES*	*NO*
Difficulty sleeping	*YES*	*NO*
Weakness	*YES*	*NO*
Lumps or thickening of the skin	*YES*	*NO*
Ringing in your ears	*YES*	*NO*
Persistent cough	*YES*	*NO*
FOR WOMEN:		
Are you or could you be pregnant?	*YES*	*NO*
History of endometriosis	*YES*	*NO*

Please list all surgeries, major injuries (fractures, dislocations, sprains), and hospitalizations you have had, beginning with the most recent

DATE *REASON FOR HOSPITALIZATION / SURGERY / INJURY*

1.
2.
3.
4.
5.

Is there anything else you would like your therapist to know?

5353 MANHATTAN CIRCLE, SUITE 103 BOULDER, CO 80303 PH: (303) 543-1201 FX: (303) 543-1206 info@avantitherapy.com www.avantitherapy.com

AVANTI THERAPY POLICIES

Cancellation Policy: It is our intention at Avanti Therapy to provide all our clients with the best possible service. In fairness to all our clients as well as our therapists, we ask that you contact us within 48 hours of a cancellation so that we may accommodate our other clients' needs for appointments. Please be aware that we ***cannot bill*** *your insurance company for the $75.00 last minute cancellation or no-show fee, which you will incur for cancellations with under 48 hours' notice. For Monday appointments, cancellations MUST be received by the 12pm the preceding Friday. We thank you for your understanding and consideration of Avanti staff as well as fellow clients.*

Payment at the time of service: While we are happy to bill your insurance, we collect copays, deductibles, cost of treatment if insurance is not being billed or if the benefits will be paid to you and outstanding balances prior to your treatment.

Insurance: We will verify your benefits, and work to ensure that you receive PT benefits with the assistance of our billing company Flatirons Practice Management. However, please be aware that you are ultimately responsible for understanding your insurance benefit for Physical Therapy, and for the charges accrued as a patient of Avanti Therapy.

Durable goods and supplies that are required for your rehabilitation, including tape and TheraBand, are rarely covered by insurance, and are the responsibility of the patient.

Signature: _____

CONSENT FOR TREATMENT

I hereby request and consent to evaluation and treatment at Avanti Therapy to be performed by physical therapists, therapists' designees, or assistants. I understand that results of treatment cannot be guaranteed.

Signature: _____

HIPAA COMPLIANCE

I hereby give consent to AVANTI THERAPY to use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment, and Health Care Operations (TPO).

I have read and understand the Avanti Notice of Privacy Practices. I understand that Avanti Therapy may use or disclose my personal health information for the purposes of providing treatment, obtaining payment, internal assessment of quality of care provided, as well as for administrative purposes related to treatment or payment. Avanti Therapy reserves the right to change the terms of our Notice of Privacy Practices at any time. A revised copy may be obtained upon request.

You have a right to request us to restrict how we use and disclose your PHI for the purposes of TPO. We are not required to grant your request, but if we do, the restriction will be binding on us.

You may revoke this consent in writing at any time except to the extent that the practice has already made disclosures in reliance upon your prior consent. If you choose not to sign this consent, or later revoke it, AVANTI THERAPY may decline to provide treatment to you and/or may be unable to except any insurance as means of payment from you.

Sign: _____ ***Date:*** _____

Print Name of Patient: _____

If you are signing as a patient's representative:

Print your name: _____

Describe your authority: _____

5353 MANHATTAN CIRCLE, SUITE 103 BOULDER, CO 80303 PH: (303) 543-1201 FX: (303) 543-1206 info@avantitherapy.com www.avantitherapy.com

avanti therapy

Waiver of Liability

I have signed up for a rehabilitation program offered by AVANTI THERAPY, LLC. I understand that participating in exercise & conditioning activities, like any physical conditioning activity presents some unavoidable risk of injury, especially to people who have preexisting injuries, illness, or medical disabilities. I understand that the use of exercise equipment also carries a risk of injury. I recognize that many changes may occur because of these exercise lessons, including possible short-term aggravation of some symptoms, feelings of tiredness, light-headedness, increased energy, mood changes, etc.

I understand that the instructions & advice presented are not a substitute for medical counseling.

I expressly assume all risks of my participation in the rehabilitation programs conducted at AVANTI THERAPY, LLC, & waive any claim which I might otherwise bring against AVANTI THERAPY, LLC, its officers, directors, shareholders, employees, trainees, & contractors because of injuries resulting from or relating to my participating in a rehabilitation program.

This is a legal instrument, if you do not fully understand it, please consult with an attorney before signing.

Date: _____

Name (Please Print): _____

Signature: _____

Signature (Parent/Guardian in under 18): _____

5353 MANHATTAN CIRCLE, SUITE 103 BOULDER, CO 80303
PH: (303) 543-1201
FX: (303) 543-1206
info@avantitherapy.com
www.avantitherapy.com

avanti therapy

Request for Release of Medical Information or Medical Records

PATIENT INFORMATION:

*Name*_____

*Address*_____

*Phone*_____ *Cell*_____

*DOB*_____

___*(CHECK IF APPLIES)*

*I authorize Avanti Therapy to SPEAK TO*_____*on my behalf.*

INFORMATION THAT MAY BE DISCUSSED (CIRCLE ALL THAT APPLY):

Treatment Information Financial Information Appointment Information Insurance Information

_____*(CHECK IF APPLIES)*

I request and authorize THE RELEASE OF MEDICAL INFORMATION to

_____.

INFORMATION REQUESTED (CIRCLE ALL THAT APPLY):

Entire Medical Record Diagnostic Testing Third party records Evaluations Daily PT notes

*Other*_____

DATES OF SERVICE REQUESTED:

*FROM:*_____ *TO:* _____

RELEASE RECORDS FROM:

Avanti Therapy
5353 Manhattan Circle, Suite 103
Boulder, CO 80303
Phone: 303-543-1201
Fax: 303-543-1206

RELEASE RECORDS TO:

*Name*_____ *Address*_____ *Phone*_____ *Fax*_____

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Practice Manager. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I certify that this request has been made voluntarily. This authorization is subject to written revocation at
any time, except to the extent that action has already been taken to comply with it. In any event, this authorization expires ninety (90) days form the date of signature. I release the above name from liability and claims of any nature pertaining to the disclosure of requested information contained in my medical records. I understand any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

SIGNATURE OF PATIENT / LEGAL GUARDIAN (IF MINOR) / MEDICAL POWER OF ATTORNEY (CIRCLE ONE PLEASE):

Signature:_____ ***Date:***_____