1831 S. 3RD ST. W. #201 MISSOULA MONTANA 59801 406-549-1669
RENEE' LEE GIBSON, PT

PATIENT INFORMATION

PLEASE FILL OUT COMPLETELY AND CLEARLY

NAME_____

DATE_____

ADDRESS_____

CITY_____

STATE_____ZIP_____PHONE (____)_____

CELL (IF YOU WISH TO RECEIVE REMINDER VIA TEXT)_____

EMAIL _____

DATE OF BIRTH_____ AGE_____

SOCIAL SECURITY NUMBER_____-_____-_____

REFERRED BY_____

OCCUPATION_____

PARTY RESPONSIBLE FOR PAYMENT IF DIFFERENT FROM PATIENT

_____

PHONE (____)_____

ADDRESS_____

CITY_____STATE_____ZIP_____

NAME AND ADDRESS OF ATTORNEY IF APPLICABLE_____

_____

MOTOR VEHICLE ACCIDENT – YES___NO___INSURANCE CO._____

PRIMARY INSURANCE

_____ID#_____

GROUP #_____IN THE NAME OF

_____

ADDRESS_____CITY_____STATE_____ZIP_____

WORKER'S COMP INSURANCE CO._____CLAIM#_____

ADDRESS_____CITY_____STATE_____ZIP_____

EMPLOYER AT TIME OF INJURY_____DATE OF INJURY_____

FIRST REPORT FILED – YES_____NO_____BY WHOM

CURRENT MEDICAL HISTORY

REASON FOR COMING IN TODAY_____

AGGRAVATING FACTORS_____

ARE YOU SEEING ANOTHER MEDICAL PRACTITIONER FOR THIS COMPLAINT ___

CURRENT MEDICATIONS

_____

_____

PAST MEDICAL HISTORY INCLUDING SURGERIES AND DATES

_____

_____

_____

_____

Welcome to Salubrious Missoula! In order to receive maximum benefit from your rehabilitation program, it is of utmost importance that you attend your therapy appointments consistently and that you follow your home instructions. Please note that it is your responsibility to schedule your appointments in advance. If you are unable to keep your appointment, please notify us at least 24 hours before your scheduled appointment by calling 406-549-1669.A no-show fee of $35.00 may be assessed for a missed appointment or a short-notice cancellation. You are subject to be discharged from our services after three missed appointments within a four-week period.

PAYMENT POLICY

Payment is due at the time of service and payment by check or cash is preferred. A $30.00 fee will be assessed for all returned checks. I also accept major credit cards and debit cards.

Please check with your insurance plan for reimbursement. I will provide you a receipt and information for reimbursement from your insurance. You will be responsible for obtaining information if your claim is denied, in which case once the information is procured from your insurance I will assist with resubmission.

PATIENT SIGNATURE_____**DATE**_____