2100 West Main St
Russellville, AR 72801
Phone (479) 968-2525
Fax (479) 968-2538

RIVER VALLEY THERAPY
SPORTS & MEDICINE

309 Union St
Dardanelle, AR 72834
Phone (479) 229-5151
Fax (479) 229-5152

Patient's Name _____ Age _____ Date of Birth _____
last first middle initial

Social Security Number _____ Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced

Address _____ Email _____

City/State/Zip _____ Home Phone _____ Cell Phone _____

Employer _____ Occupation _____ Business Phone _____

If married, spouse's name _____ Date of Birth _____

Social Security Number _____ Spouse's Employer _____

Occupation _____ Business Phone _____

In case of an emergency, call _____ Phone _____ Relation _____

If Patient is a Minor, Please Complete the Following

Father's Name _____ Social Security Number _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____ Home Phone _____

Employer _____ Occupation _____ Business Phone _____

Mother's Name _____ Social Security Number _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____ Home Phone _____

Employer _____ Occupation _____ Business Phone _____

Financial Agreement

As a courtesy, we attempt to verify insurance benefits for our patients. This in no way guarantees that your insurance company will pay exactly as quoted, since they will not guarantee benefits over the phone. This facility is not responsible for attaining or being aware of your policy requirements for referrals from your primary care physician, pre-certifications, or limits with your specific policy. We urge you to familiarize yourself with your health care benefits. Your insurance policy is a contract between you and your insurance company; therefore the responsibility lies with you, the patient, to be aware of this information. We will assist you if necessary to help you obtain this information.
I understand I will be billed and agree to pay any co-pays, deductible, or balances unpaid by my insurance provider.

Signature: _____ Date: _____

Assignment of Benefits

I request payment and assign benefits of authorized insurance, prepaid medical plan, Medicare or Medicaid benefits to River Valley Therapy & Sports Medicine, Inc. for any services provided. A photocopy of this assignment is to be considered as valid as the original.

Signature: _____ Date: _____

ID#:

Name _____ **MEDICAL INFORMATION** ID#:

What is the problem for which you need therapy? _____

Referring Physician: _____ Family Physician: _____

Whom can we thank for this referral? _____ Website Yellow Pages Other _____

Is treatment result of surgery? □Yes □No If yes, please give surgery date _____

Is treatment result of injury? □Yes □No If yes, was injury on the job? □Yes □No Auto Accident? □Yes □No

If treatment is result of injury, please give injury date _____

Please check previous medical history:

□ Arthritis
□ Blood Disease
□ Cancer
□ Circulation
□ Degenerative Joint Disease
□ Depression
□ Diabetes
□ Heart Problems
□ Hepatitis (Type_____)
□ High Blood Pressure
□ Mental Illness
□ Respiratory / Lung
□ Stroke
□ Tuberculosis
□ Other: _____

Please list your current medications **with dosages** (Include prescriptions, over-the-counter, cannabis/cannabidiol, herbals & supplements):

_____
_____
_____
_____
_____
_____

Please list any previous surgeries with dates:

_____
_____
_____

Please list allergies to medications of any kind:

_____
_____

Do you currently use tobacco/vape products? □Yes □No

Have you received the following services this calendar year?

□ Chiropractor □ Physical Therapy □ Occupational Therapy □ Speech Therapy

Patient Health Questionnaire (PHQ-2)

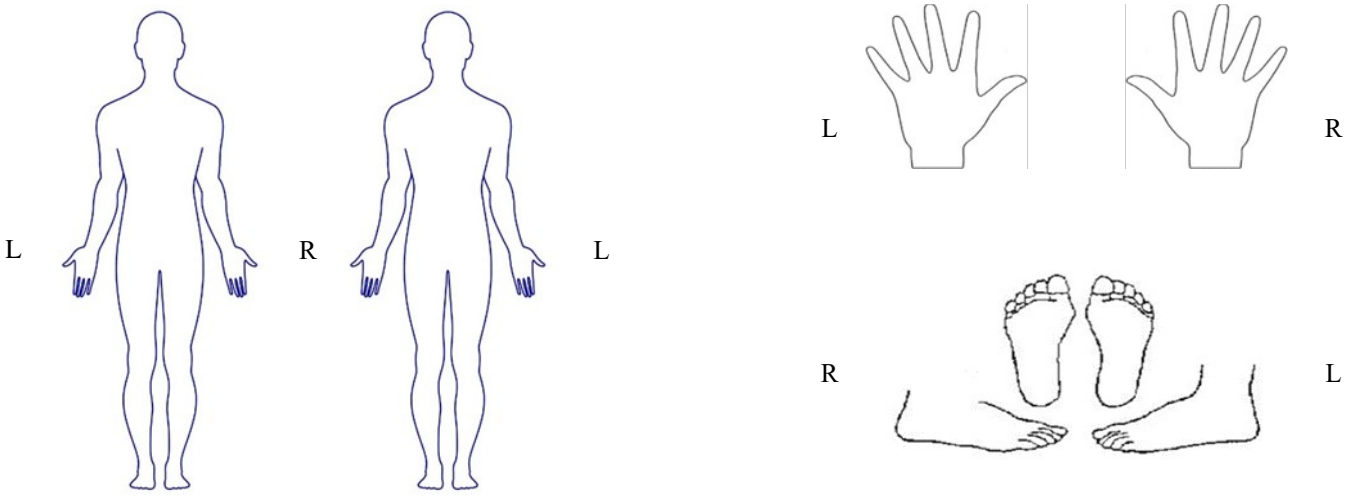
The PHQ-2 inquires about the frequency of a depressed mood over the past two weeks. The purpose of the PHQ-2 is to screen for depression in a "first step" approach.

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				

PAIN PROFILE

Using the symbols below, please mark the areas you are having discomfort:

Aching xxxxxx
Burning ////////////
Numbness 000000000



Please rate your pain using the following scale:

0	1	2	3	4	5	6	7	8	9	10
No	Mild		Moderate	Distressed		Severe		Very Severe		Excruciating

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Welcome to **River Valley Therapy & Sports Medicine.** We are happy that you have chosen us for your rehabilitation needs. We will do everything in our power to make your therapy experience a positive one.

Statement of Rights and Responsibilities

You have the right to:

1. Be treated with dignity, courtesy, and respect, and have your property treated with respect.
2. Receive competent, quality services regardless of age, race, color, national origin, religion, sex, disability, or any other category protected by law.
3. Expect River Valley Therapy to coordinate your care through regular communication with your physician, caregivers and other providers.
4. Have visitors attend therapy sessions if approved by therapist and the visitation would not interfere with therapy session.
5. Receive an explanation of any responsibilities you or your family/caregiver may have in the care process.
6. Refuse treatment to the extent permitted by law and to be informed of the consequences of this right.
7. If you do not have insurance or request that we not bill your insurance, you have the right to receive a "Good Faith Estimate" explaining how much your care will cost upon request.
8. Request a review of the information practices utilized by River Valley Therapy & Sports Medicine, Inc. regarding the use and disclosure of your Protected Health Information. A complete description of these practices is available on the premises for your review at any time and may be requested prior to signing this statement. You may request restriction on uses and disclosures of your Protected Health Information in order to carry out treatment, payment, and other related healthcare operations, but River Valley Therapy & Sports Medicine is not required to agree to any restrictions requested.

You have the responsibility to:

1. Provide complete and accurate information about your health and for reporting effects of physical therapy treatment.
2. Attend scheduled therapy sessions; participate in treatment activities and to be compliant with home exercise programs outlined by the treatment plan given to you.
3. Be considerate of the rights of other River Valley Therapy & Sports Medicine patients while participating in your rehabilitation program.
4. Notify the clinic as soon as possible concerning cancellation of scheduled appointment to allow adequate time to reschedule other patients.
5. Pay any balance not covered by your insurance, including co-pays, co-insurance, or deductibles. You will be billed and expected to pay the balance.

*** I have read and understand the above Patient Rights and Responsibilities.**

Signature: _____Date: _____

Consent for Purposes of Treatment, Payment and Healthcare Operations

I understand that my Protected Health Information means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This Protected Health Information relates to my past, present, or future physical or mental health or condition. This information identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to the use or disclosure of my Protected Health Information by River Valley Therapy & Sports Medicine for the purpose of diagnosing or providing treatment to me. I voluntarily consent to receive therapy services provided by River Valley Therapy & Sports Medicine, Inc.

Signature: _____ Date: _____

I consent to the use or disclosure of my Protected Health Information by River Valley Therapy & Sports Medicine, Inc. for the purpose of obtaining payment of my health care bills from authorized insurance, prepaid medical plans, Medicare or Medicaid to River Valley Therapy & Sports Medicine, Inc.

Signature: _____ Date: _____

WellRx Questionnaire

Patient Name: _____DOB: _____

Male ☑ Female ☐

*****_This questionnaire is new to therapy services for the 2024 calendar year and is required by government agencies. Thank you for understanding._

	Yes	**No**
In the past 2 months, did you or others you live with eat smaller meals or skip meals because you didn't have money for food?		
Are you homeless or worried that you might be in the future?		
Do you have trouble paying for your utilities (gas, electricity, phone)?		
Do you have trouble finding or paying for a ride?		
Do you need daycare, or better daycare, for your kids?		
Are you unemployed or without regular income?		
Do you need help finding a better job?		
Do you need help getting more education?		
Are you concerned about someone in your home using drugs or alcohol?		
Do you feel unsafe in your daily life?		
Is anyone in your home threatening or abusing you?		