PATIENT INFORMATION

Patient Name: _____ Gender: _____
Date of Birth: _____ Social Security: ___ - ___ - ___
Mailing Address: _____ Marital Status: S M O
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Referring Doctor: _____
Employer: _____ Work Phone: _____

INSURED INFORMATION

Insured Name: _____ S.S. # ___ - ___ - ___
Date of Birth: _____ Relationship to patient: _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Employer: _____ Work Phone: _____
Home Phone: _____ Cell Phone: _____

PRIMARY INSURANCE

Insurance Co: _____ Co-Pay _____
Address: _____ Phone: _____
City: _____ State: _____ Zip Code: _____
Policy #: _____ Group #: _____
Work Related? Yes No Claim #: _____
Adjuster's Name: _____
Adjuster's #: _____ Date of injury: _____

SECONDARY INSURANCE

Insured Name: _____ S.S. # ___ - ___ - ___
Date of Birth: _____ Relationship to patient: _____
Insurance Co: _____ Co-Pay _____
Address: _____ Phone: _____
City: _____ State: _____ Zip Code: _____
Policy #: _____ Group #: _____

AUTHORIZATION

Insurance Assignment and Medical Records Release:

I, the undersigned, do hereby authorize my Insurance carrier(s) to pay directly to ProRehab Physical Therapy, the insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for any charges not covered by said insurance carrier(s), including co-pay and/or deductible amounts. I, the undersigned, agree to pay all attorney fees, court costs, filing fees, including charges or commissions that may be assessed to me by any collection agency retained to pursue such matters. I further agree to pay interest in the amount of 1.5% per month on any balance over 90 days. I do hereby give my permission to ProRehab Physical Therapy to furnish my insurance carrier(s) any and all informaiton pertaining to my medical records.

Signature: _____ Date: _____

OTHER

How did you hear about ProRehab Physical Therapy?

Telephone Book _____ Doctor _____ Former Patient _____
Internet/Website _____ Family/Friend _____ Staff Member _____

ProRehab
Physical Therapy
Bookcliff Medical Plaza
590 East 100 North Suite #1
Price, Utah 84501

Phone: (435)613-1500
Fax: (435)613-1501

Name: DOB:
Referring Physician:
Reason for visit:

What part of the body is involved? (please circle all that apply)

Arm	R	L	Ankle	R	L	Hand	R	L	Back
Finger:____	R	L	Foot	R	L	Wrist	R	L	Neck
Knee	R	L	Leg	R	L	Elbow	R	L	Pelvis
Shoulder	R	L	Toe:___	R	L	Hip	R	L	Other:

How Severe is you pain? (Please Circle) 1 2 3 4 5 6 7 8 9 10

For the following, circle yes or no. If yes, please provide a brief explanation.

Did you have surgery? YES NO Surgery Type: _____ Date: _____
Is it due to injury? YES NO Date of injury: _____
If YES, please explain: _____
Is the injury work related? YES NO
If YES, please explain: _____
Due to motor vehicle accident? YES NO
If YES, please explain: _____
Are you currently receiving Home Health Services? YES NO
If YES, from where? _____
Do you have a pace maker? YES NO

Please list all medications you are currently taking below:

MEDICATION	Dose per day	MEDICATION	Dose per day
1.		7.	
2.		8.	
3.		9.	
4.		10.	
5.		11.	
6.		12.	

PATIENT SIGNATURE: _____ **DATE:** _____

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PAYMENT AGREEMENT

I/We agree to pay all charges and fees incurred herein as shown by the statements, promptly upon presentment thereof, unless credit arrangements are agreed upon in writing. Charges shown by statements are deemed to be correct and reasonable unless protested in writing within thirty days of billing date. If this account becomes delinquent, I/We agree to pay interest on the unpaid balance at the rate of 1.5% per month (18% per annum). ***I/We further agree to pay all court costs, attorney's fees and collection agency commissions incurred in collecting this account, whether or not suit is filed, and understand that collection agency commissions might be as much as 50% of the principal balance owing.***

PATIENT: _____ DATE: _____

GUARANTOR: _____ DATE: _____

Jeffrey Ohlwiler, President

Michael Gagon, Vice President

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HIPAA Compliance Form

I, the undersigned, do hereby acknowledge that I was made aware of the NOTICE OF PRIVACY PRACTICES by ProRehab Physical Therapy and, having read said documents, confirm my total compliance with them. I understand that the practices established by HIPAA are for the protection of personal medical records in compliance with current law. I recognize that ProRehab Physical Therapy reserves the right to change their privacy practices and terms per discretion, provided that said changes are permitted by law. I further understand that ProRehab Physical Therapy has the right to disclose any or all information provided by me, the patient, in any event that complies with the privacy practices previously mentioned.

Signed _____ Date _____