

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: <p>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 information pertaining to my medical records.</p> 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 your 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.***

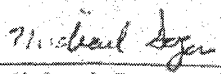
PATIENT: _____

DATE: _____

GUARANTOR: _____

DATE: _____


Jeffrey Chilwiler, President


Michael Gagon, Vice President



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Physical Therapy**
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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 _____