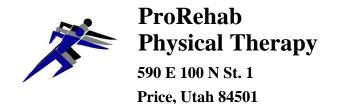
PATIENT INFORMATION	City: _ Home phone: _ Referring Physic Employer:	oion:	C 11 D1		S	<u>-</u> М	O	- - -		
INSURED INFORMATION			State:	S.S. #				- -		
PRIMARY INSURANCE	Insurance Co:	Yes No	<b>Q</b>	Co-Pay Phone: Zip Code: Group #:  Date of injury:				-		
SECONDARY INSURANC	Insurance Co:Address:			S.S. # nship to patient: Co-Pay Phone: Zip Code: 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 information pertaining to my medical records.  Signature:  Date:									
OTHER	Telepho	oout ProRehab Physic one Book /Website	cal Therapy?  Doctor  Family/Friend	Former Pa Staff Mer				-		



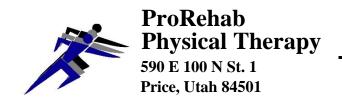
## **PAYMENT AGREEMENT**

Phone: (435)613-1500

Fax: (435)613-1501

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.

By adding your email address, you agree	to receive your statements electronically.
Email Address:	
Patient:	Date:
Guarantor:	Date:
MANA OT	
If Allie PT	
Jeffrey Ohlwiler, President	Michael Gagon, Vice President



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

## **HIPAA** Compliance Form

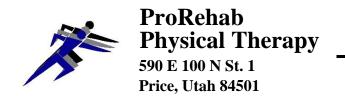
I, the undersigned, do hereby acknowledge that I was made aware of the NOTICE OF PRIVACY PRACTICES by ProRehab Physical Therapy and, having read said documents, confirm my total compliance with them. I understand that the practices established by HIPAA are for the protection of personal medical records 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. The Practice provides this form to comply with the Health Information Portability and Accountability Act of 1996 (HIPAA).

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

The patient understands that:

- PHI may be disclosed or used for treatment, payment or health care operations.
- The practice has Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

Signature of patient or responsible party	Date	



## **Health Questionnaire**

Phone: (435)613-1500

Fax: (435)613-1501

		IICa	1111	Qui	CSU	UIII	ıan	C						
Name					_		D	ate	of	Bir	th_			
What n	oart of the body is inv	olvod? Pla	2260	irel	الدو	that	anr	.lx7•						
vv nat p	Back	Shoulder		R	c an	шаі	app	-	- <del>I</del> ip			L	R	
	Neck	Elbow	L						Inp	<b>e</b> .			R	
	Pelvis	Wrist							\nk			L	R	
	Other	Hand							Foot			L		
		Finger		R					Toes				R	
What is	s your current pain le	evel? (	) 1	2	3	4 5	5 6	<b>5</b> '	7	8	9	10		
For the	following questions,	please cir	cle Y	ES (	or N	0								
When v	vas the onset of your s	ymptoms?				App	prox	ima	ate l	Dat	e:_			
Is this r	elated to a recent surge	ery?	YI	ES o	r NC	)			7	Гур	e:_			
Is this d	lue to a work-related in	njury?	YI	ES o	r NC	)					_			
	Please explain:													
Is this d	lue to a motor vehicle	accident?	YI	ES o	r NC	)								
	Please explain:													
Were yo	ou recently discharged	from home	e heal	lth s	ervic	es?								
	Date of discharge:							C	omp	pan	y:_			
Past M	edical History:				Pl	ease	che	ck :	all 1	tha	t a	pply	:	
[ ] Dia	betes	[ ] Trau	matic	Bra	in In	jury		[	] ]	Rhe	eun	natoi	d Arthritis	
[] Hig	h Blood Pressure	[ ] Curre	[ ] Current Infection					[ ] Osteoporosis						
[] Hig	h Cholesterol	[ ] Kidn						[ ] Asthma or COPD						
[ ] Hea	art Disease	[ ] Liver Disease					[ ] Stroke/CVA							
[ ] Hea	art Arrhythmia	[ ] Cancer					[ ] Seizures							
[ ] Pacemaker [ ] Immu				unocompromised				[ ] Dizzii				ness/Fainting		
Allergie	es:													
_	s Surgeries:													
	t Medications (may pro	ovide list):												
	` 71	,												