PATIENT INFORMATION

Patient Name: _____ Gender _____

Date of Birth: _____ Age: _____ Social Security ___ - ___ - ____

Mailing Address: _____ Marital Status: S M O

City: _____ State: _____ Zip Code: _____

Home phone: _____ Cell Phone: _____

Referring Physician: _____

Employer:

INSURED INFORMATIO

Insured Name: _____ S.S. # ___ - ___ - ____

Date of Birth: _____ Relationship to patient: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Employer: _____ Work Phone: _____

Cell phone: Home 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 INSURANC

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
590 E 100 N St. 1
Price, Utah 84501

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

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.***

By adding your email address, you agree to receive your statements electronically.

Email Address: _____

Patient: _____ Date: _____

Guarantor: _____ Date: _____

Jeffrey Ohlwiler, President

Michael Gagon, Vice President

ProRehab
Physical Therapy
590 E 100 N St. 1
Price, Utah 84501

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

ProRehab
Physical Therapy
590 E 100 N St. 1
Price, Utah 84501

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

Health Questionnaire

Name _____ Date of Birth _____

What part of the body is involved? Please circle all that apply:

Back	Shoulder	L	R	Hip	L	R
Neck	Elbow	L	R	Knee	L	R
Pelvis	Wrist	L	R	Ankle	L	R
Other	Hand	L	R	Foot	L	R
	Finger	L	R	Toes	L	R

What is your current pain level? 0 1 2 3 4 5 6 7 8 9 10

For the following questions, please circle YES or NO

When was the onset of your symptoms? Approximate Date: _____

Is this related to a recent surgery? YES or NO Type: _____

Date: _____

Is this due to a work-related injury? YES or NO

Please explain: _____

Is this due to a motor vehicle accident? YES or NO

Please explain: _____

Were you recently discharged from home health services?

Date of discharge: _____ Company: _____

Past Medical History: **Please check all that apply:**

[ ] Diabetes	[ ] Traumatic Brain Injury	[ ] Rheumatoid Arthritis
[ ] High Blood Pressure	[ ] Current Infection	[ ] Osteoporosis
[ ] High Cholesterol	[ ] Kidney Disease	[ ] Asthma or COPD
[ ] Heart Disease	[ ] Liver Disease	[ ] Stroke/CVA
[ ] Heart Arrhythmia	[ ] Cancer	[ ] Seizures
[ ] Pacemaker	[ ] Immunocompromised	[ ] Dizziness/Fainting

Allergies: _____

Previous Surgeries: _____

Current Medications (may provide list): _____

_____