Patient Information

Patient Name _____ S.S.# ____-____-____
Mailing Address _____ Home Phone _____
City _____ State _____ Zip _____
Date of Birth _____ Age _____ Marital Status S M O
Employer _____ Work Phone _____
Referring Doctor _____
Cell# _____

Insured Information

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

Primary Insurance

Insurance Co. _____ Co-Pay _____
Address _____ Phone _____
City _____ State _____ Zip _____
Policy # _____ Group # _____

Work related ? Yes No Claim# _____
Adjuster's # _____
Adjuster Name _____ Date of Injury _____

Secondary Insurance

Insurance Co _____ Co-Pay _____
Address _____ Phone _____
City _____ State _____ Zip _____
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 information pertaining to my medical records.

Signature: _____ Date: _____

ProRehab
Physical Therapy

BookCliff Medical Plaza
590 East 100 North Suite #1
Price, Utah 84501

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

PATIENT NAME: _____ **DOB:** _____
DOCTOR NAME: _____
REASON FOR VISIT: _____

What body part is involved? (please check all that apply below)

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

Type of Surgery for current condition: _____ **Surgery Date:** _____ **RIGHT - LEFT**
Due to injury? _____ **Date of injury:** _____ **Date pain initiated for Non Injury:** _____
Injury due to accident? _____ **Explain:** _____
Explain if current condition is due to a previous injury: _____
How long have you had current pain? _____

On a scale of 0-10 (10 being the worst), how severe is your pain: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

What is the quality of your pain: ☐Sharp ☐Dull ☐Stabbing ☐Throbbing ☐Aching ☐Burning

Do you have the following? ☐Bruising ☐Joints Giving Way ☐Hands Feeling Clumsy ☐Locking/Catching ☐Weakness ☐Numbness ☐Poor Balance ☐Loss of Control of Bladder ☐Tingling ☐Swelling

Do you have a Pace Maker? _____ **Height:** _____ **Weight:** _____
Are you currently receiving Home Health Services: _____ **If Yes Where?** _____

Do you have any history of an allergic reaction to medications or other substances?
☐No known allergies ☐Yes, specify:

Are you currently taking any of the following medications? If so, indicate by marking the check box next to the medication.

NAME OF MEDICATION	DOSE (include strength and number of pills per day	NAME OF MEDICATION	DOSE (include strength and number of pills per day
1.		7.	
2.		8.	
3.		9.	
4.		10.	
5.		11.	
6.		12.	

Is your injury/condition a result of a work related incident? _____
Is your injury/condition a result of a motor vehicle accident? _____
Please list any complication with your current condition.: _____

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 ½ % per month (18% per annum). ***I/We further agree to pay all court costs, attorney's fess 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.***

DATED this _____ day of _____, 20__.

_____
PATIENT

_____
GUARANTOR

_____
GUARANTOR

_____
Jeffrey Ohlwiler, President

_____
Michael Gagon, Vice President

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 their 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_____