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

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

Patient Information

Patient Name: _____

Preferred Name (if different): _____ Date of Birth: _____

Gender: _____ SS#: _____

Phone Number: _____ Text Reminders: Y N

Mailing Address:_____

Email Address: _____

Emergency Contact:

Name: _____ Number: _____ Relationship: _____

Employer: _____ Referring Physician: _____

Insured Information (if different)

Insured Name: _____ Date of Birth: _____

Relationship to Patient: _____ Gender: _____

Mailing Address: _____

Phone Number: _____

Authorization

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: _____

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Primary Insurance Information

Insurance Company: _____

Policy Number: _____ Group Number: _____

Address: _____

Phone Number: _____

Secondary Insurance Information

Insurance Company: _____

Policy Number: _____ Group Number: _____

Address: _____

Phone Number: _____

Worker's Compensation Information

Insurance Company: _____

Claim Number: _____ Date of Injury: _____

Adjuster Name: _____

Phone Number: _____

Fax Number: _____

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Informed Consent

Physical therapy is a patient care service that is provided in order to manage a wide variety of conditions. Services are provided to individuals of all ages regardless of gender, color, ethnicity, creed, national origin, or disability.

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. ProRehab Physical Therapy does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. I authorize the release of my medical information to appropriate third parties.

Please check below for your billing statement preference:
[ ] Electronically via E-mail
[ ] Paper statement via Mail

Patient Name _____

Signature _____ Date _____

Responsible Party (if different) _____

Relationship to Patient _____

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Name _____ Date of Birth _____

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

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

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 Date of Injury: _____

Please Explain: _____

Is this due to a motor vehicle accident? YES or NO Date of Accident: _____

Please Explain: _____

Were you recently discharged from home health services? YES or NO

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 (if you have a list, please provide): _____

_____

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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. 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

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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.***

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