Welcome To Professional Physical Therapy & Sports Medicine

Patient Information – Please print clearly and use **Legal/Insurance** names

Last Name of Patient _____ First Name _____

Address _____ City_____ State_____ Zip Code_____

Home # _____ Cell # _____ Work # _____

Birth Date _____/_____/_____ (MM/DD/YYYY) Age _____ Male / Female - Married / Single

E-mail Address: _____ Social Security # _____ -_____- _____

Referring Physician _____ Primary Physician _____

Employer _____ Occupation _____

Have you been to any other Physical Therapy office? Yes / No Facility Name: _____
Have you had Home Health Physical Therapy recently? Yes / No Number of visits:_____
How did you hear about us? _____

Date of Injury _____/_____/_____ and/or Date of Surgery _____/_____/_____
How and where were you injured? _____
What is your biggest complaint? _____
What increased your pain? _____
What decreases your pain? _____
What medications are you currently taking? _____
Rating your pain on a scale of 1 to 10 with 10 being the most painful, circle where your pain is:

0 1 2 3 4 5 6 7 8 9 10

Primary Insurance Information

Policy Holder's Name _____ Policy Holder's Date of Birth _____

Employer _____ Phone # _____ SSN _____

How are you related to the patient? _____ Insurance Company _____

Secondary Insurance Information

Policy Holder's Name _____ Policy Holder's Date of Birth _____

Employer _____ Phone # _____ SSN _____

How are you related to the patient? _____ Insurance Company _____

RESPONSIBLE PARENT/GUARDIAN INFORMATION (if different from above)
Last Name_____ First Name_____
Address_____ City_____ State_____ Zip Code_____
Home#_____ Cell#_____ Work#_____
Date of Birth_____ SSN_____ Employer_____
How are you related to the patient? _____

Worker's Comp or Auto Information (if applicable)

Policy Holder's Name _____ Policy Holder's DOB:_____
Insurance Company_____ ID or Claim #_____
Adjuster's Name_____ Insurance/Adjuster's Phone #_____
Attorney Name_____ Attorney's Phone # _____

Orrock & Mendenhall Physical Therapy & Sports Medicine

MEDICAL SCREENING QUESTIONNAIRE

Name: _____ Date: _____ Age: _____

Height _____ Weight _____

Have you fallen in the past year? ☐ **Yes** ☐ **No** If yes, how many times? _____

Do you have a pacemaker? ☐ **Yes** ☐ **No**

Do you smoke? ☐**Yes** ☐**No**

Are you latex sensitive? ☐ **Yes** ☐ **No**

FOR WOMEN: Are you currently pregnant or think you might be pregnant? ☐**Yes** ☐ **No**

ALLERGIES: List any medication(s) you are allergic to: _____

Have you RECENTLY noted any of the following? (Check all that apply)

☐ fatigue	☐ numbness or tingling	☐ constipation
☐ fever/chills/sweats	☐ muscle weakness	☐ diarrhea
☐ nausea/vomiting	☐ dizziness/lightheadedness	☐ shortness of breath
☐ weight loss/gain	☐ heartburn/indigestion	☐ fainting
☐ cough	☐ difficulty maintaining balance while walking	☐ difficulty swallowing
☐ falls	☐ changes in bowel or bladder function	☐ headaches

Have you EVER been diagnosed with any of the following conditions? (Check all that apply)

☐ cancer	☐ depression	☐ thyroid problems	☐ heart problems
☐ lung problems	☐ diabetes	☐ chest pain/angina	☐ tuberculosis
☐ osteoporosis	☐ high blood pressure	☐ asthma	☐ multiple sclerosis
☐ circulation problems	☐ rheumatoid arthritis	☐ epilepsy	☐ blood clots
☐ other arthritic condition	☐ eye problems/infection	☐ stroke	☐ ulcers
☐ anemia	☐ bladder/urinary tract infection	☐ hepatitis	☐ pneumonia
☐ kidney problem/infection	☐ pelvic inflammatory disease	☐ bone or joint infection	
☐ liver problems	☐ sexually transmitted disease/HIV	☐ chemical dependency (i.e. alcoholism)	

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions? (Check all that apply)

☐ cancer	☐ diabetes	☐ tuberculosis	☐ heart problems
☐ stroke	☐ thyroid problems	☐ high blood pressure	☐ depression
☐ blood clots			

During the past month have you been feeling down, depressed or hopeless? ☐ **Yes** ☐ **No**

During the past month have you been bothered by having little interest or pleasure in doing things? ☐ **Yes** ☐ **No**

If yes to either, is this something with which you would like help? ☐ **Yes** ☐ **Yes, but NOT today** ☐ **No**

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

_____

_____

Have you ever taken steroid medications for any medical conditions? ☐ **Yes** ☐ **No**

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? ☐ **Yes** ☐ **No**

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

_____

Professional Physical Therapy & Sports Medicine

WELCOME

Mission Statement:
We treat every patient that comes into our clinic better than we, ourselves, would want to be treated.

As a new patient, we would like to acquaint you with some of our office policies:

Please be aware that if your insurance company requires pre-authorization or pre-certification in order to qualify for treatment coverage, it should be done before any physical therapy treatments are administered. If your insurance company requires a prescription or referral from your physician for physical therapy coverage, you must present that at the time of your initial visit to our clinics. If the prescribed time limits on your referral expire while you are still receiving physical therapy treatments, please contact your physician to obtain updates as necessary for your insurance coverage to remain in effect.

Our office is staffed to assist you with the billing of your insurance company for the payment of your physical therapy treatments as benefit to you. We are also willing and ready to answer any questions that you may have about the coverage benefits that your insurance does, or does not, allow in regards to your physical therapy treatment benefits within our clinics. However, please understand that the ultimate responsibility of the payment of our services rendered on your behalf is up to you. Every insurance company has variances in their coverage policies and protocols. We will contact your insurance company to help you understand how those policies directly affect your individual coverage, but recommend that you become familiar with your insurance policy in order to better understand your coverage benefits.

If your insurance company requires a co-payment for your office visits, we require that you pay that in our clinics the time of service. We accept personal checks, cash, Visa, Discover, and MasterCard..

If you are unable to keep your scheduled appointment, we request that you contact the clinic where you are scheduled to be treated at least 24 hours in advance of your appointment to reschedule. A $20 fee will be assessed to your account if you fail to show for a scheduled appointment.

If you do not have insurance that covers physical therapy treatments, we request that you pay for your treatment at the time that the service is rendered. Our office managers can also assist you with setting up a helpful and convenient payment plan.

If you ever have any questions or concerns regarding your account, our friendly and knowledgeable billing staff are able to assist you. Our billing department hours are Monday thru Friday from 8 am to 5 pm.

Please note we welcome your children during your therapy, but please be courteous to our staff and other patients by NOT leaving them unattended. We are not responsible for WATCHING them or held liable for any INJURIES that may occur.

I have read, understand and agree to the policies of Professional Physical Therapy & Sports Medicine as stated above.

DATE:_____ SIGNATURE:_____

Professional Physical Therapy & Sports Medicine

POLICY ON PAYMENT AND AUTHORIZATION FOR PHYSICAL THERAPY TREATMENT

All medical care is due and payable when complete unless prior arrangements have been specifically made. A "Repeat Billing Charge" will be added to all accounts to defray the cost of sending repeat statements. Your account will also be charged interest in the amount of 1.5% per Month on balances over 30 days. In the event any balance due here under is not paid as agreed, the undersigned jointly and overly agree to pay all costs incurred in said unpaid balances. Should there be a just cause to turn your account over to a collection agency an additional 33% will be added to your account including collection and legal fees.

I/We hereby consent to authorize the performances of all treatments and services by the Physical Therapist and staff, which may deem advisable and agree to pay for all treatments and services performed. I also herby authorize release of information requested of my insurance company and/or its representative. I also direct my insurance company to send payments directly to professional P.T. I fully understand that this agreement of consent will continue until canceled by me in writing.

I hereby instruct the above named Insurance Company to pay by check made out and mailed directly to:
Professional Physical Therapy & Sports Medicine
1325 South 800 East Suite 215
Orem, UT 84097

For professional or medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above professional for non-covered service and/or fees, over and above the insurance payment or as required by my insurance policy.

A photocopy of this assignment shall be considered effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance. I also agree to pay for any services rendered beyond any authorized visits from my insurance company.

DATE:_____ SIGNATURE:_____

An $8.00 fee will be added to my account if co pays are not paid at the time of service and it becomes necessary to send a statement requesting payment on my account.

Methods of payment we accept are as follows: Cash, Check, Visa, MasterCard, and Discover.

HIPAA NOTICE OF PRIVACY PRACTICES

Professional Physical Therapy & Sports Medicine

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of privacy describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, Payment or Operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information, which may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physical therapist, our office staff and others outside of our office that are involved in your care and treatment for the purposes of providing health care services to you, to pay your health care bills, to support the operation of the physical therapist's practice, and may other use require law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected information, as necessary, to a physician to whom you have been referred to our office by to ensure that the physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment from your health care services. For example, obtaining approval for physical therapy treatment may require that your relevant protected health information be disclosed to health plan to obtain approval for treatment.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of you physical therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of interns, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to interns that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when our physical therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceeding: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Under the Law, we must make disclosures to you and when required by the secretary of the Department of Health and Human services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physical therapist or the physical therapist's practice has taken action in reliance on the use or disclosure indicated in authorization.

I HAVE BEEN NOTIFIED OF THE HIPAA PRIVACY PRACTICES BY PROFESSIONAL PHYSICAL THERAPY AND SPORTS MEDICINE.

DATE: _____ SIGNATURE: _____