Moab Physical Therapy and Rehabilitation
131 E 100 S. Moab, Utah 84532 Phone: 435-210-1985

MOAB PHYSICAL THERAPY & REHABILITATION

PERSONAL INFORMATION

PLEASE COMPLETE ALL SECTIONS		
Full Legal Name	Home Phone	Cell Phone
Address	City	Zip Code
Email address (print clearly)	**Date of Birth:** _____ / _____ / _____	social security # last 4 digits -___ ___ ___ ___
Preferred appointment notification: ___ **EMAIL** ___ **TEXT** ___**Phone call**	Marital Status __single __married __divorced __widowed __separated	
Employer	Work phone	__ Full time __ part time __ unemployed __ retired
Other employment	Work phone	__ Full time __ part time
Primary Physician:	**Referring** Physician:	Physician phone
Emergency contact: Name	**Emergency** Phone #	**Relationship**
IF NOT PRIMARY policy holder on your insurance plan: Provide full Name	Date of Birth of primary insured party: ___ / ___ / _____	

I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of my account for any professional services rendered. I am also responsible for recognizing insurance status including, but not limited to, benefits and allowable visits. I have read all the information on this page and certify that the information I provided is true and correct to the best of my knowledge. I also agree to notify Moab Physical Therapy and Rehabilitation of any changes in the above information.

Signature: _____ Date: _____

Signature of Parent or Guardian (if minor): _____ Date: _____

CONSENT FOR TREATMENT:
I hereby give permission for Moab Physical Therapy and Rehabilitation employees and professional staff to render treatment to myself. I understand that I will be given all available pertinent information prior to the treatment being rendered. I will be given the opportunity to ask questions and have them answered to my satisfaction. I understand that I may decline treatment at any time.

_____ _____ _____
SIGNATURE DATE PLEASE PRINT NAME

CONSENT TO RELEASE / OBTAIN MEDICAL INFORMATION:
Permission is hereby grated to Moab Physical Therapy and Rehabilitation to release information to my insurance company, my referring primary care physician. If this is a work-related injury and/or third party payor I hereby grant permission to release treatment notes and relevant medical history pertaining to my injury to my employer, attorney, workers compensation carrier, and/or referring physician related to this injury.

_____ _____ _____
SIGNATURE DATE PLEASE PRINT NAME

*Please present current insurance cards and legal identification to be copied as part of your medical records.

** If you are insured by Medicare, please present your current medications list to be kept on file. Thank you.

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MEDICAL HISTORY

<table>
<tr><td colspan="4">PLEASE COMPLETE ALL SECTIONS (circle options when asked)</td></tr>
<tr><td colspan="2">Mechanism of Injury:</td><td colspan="1">Injury Date:
Have you had: XRAY / MRI / CT scan / other</td><td>Surgery: YES / NO
Date: _____</td></tr>
<tr><td colspan="3">Have you had physical therapy this year? YES / NO
How did you hear about us?</td><td>How many visits?</td></tr>
<tr><td colspan="4">Are you undergoing, or undergone any treatment for this injury? MD / DC / PT / Massage / Other
Please Explain:</td></tr>
<tr><td colspan="4">Has your primary care physician ever warned you against exercise? YES / NO
Please Explain:</td></tr>
<tr><td colspan="2">Are you currently engaged in some form of exercise?
YES / NO
Please Explain:</td><td colspan="2">Do you currently have restrictions at work due to injury or currently unable to work? YES / NO
Please Explain:</td></tr>
<tr><td colspan="4">Have you ever been diagnosed by a physician with any of the following:
□ History of Cancer □ Diabetes □ Fibromyalgia □ Osteoporosis
□ Cardiac Disease □ Arthritis □ High Blood Pressure □ Respiratory Disease
□ Chronic Fatigue □ Epilepsy □ Myofascial pain □ OTHER: _____</td></tr>
<tr><td colspan="4">Have you experienced any of the following symptoms in the past few weeks to 1 month:
□ Abdominal or Chest Pain □ Dizziness or Fainting □ Nervousness □ Frequent Urination
□ Unexplained Weight Loss □ Illness or Fever □ Severe Fatigue □ Loss of Balance
□ Irregular Heart Beat □ Migraines/ Headache □ Depression □ Shortness of Breath</td></tr>
<tr><td colspan="2">Are you pregnant? YES / NO</td><td colspan="2">Please list any medical conditions not mentioned above:</td></tr>
<tr><td colspan="4">Please list all current over the counter or prescription medications:</td></tr>
<tr><td colspan="4">Prior Accidents or Injuries:</td></tr>
<tr><td colspan="4">Family Health History:</td></tr>
<tr><td colspan="2">Are you a current or PRIOR tobacco smoker? YES / NO</td><td colspan="2">Alcohol: □ Daily □ Weekly □ Occasional □ Never</td></tr>
<tr><td colspan="2">Caffeine: □ Daily □ Weekly □ Occasional □ Never</td><td colspan="2">Drugs: □ Daily □ Weekly □ Occasional □ Never</td></tr>
</table>

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

_____ _____ _____

SIGNATURE DATE PLEASE PRINT NAME

MOAB PHYSICAL THERAPY & REHABILITATION

131 E 100 S Moab, Utah 84532

Patient Financial Policies

HEALTH INSURANCE: As a courtesy to you, we will verify health insurance benefits and bill your insurance company. It is ultimately your responsibility to understand your health insurance benefits and to pay for the balance of your bill. If problems with payment from your insurance arise, it is your responsibility to contact your insurance company.

CO-PAYMENTS/CO-INSURANCE/DEDUCTIBLE: It is our policy to collect co-payments, co-insurance and deductible amounts at the time of service. Co-insurance and deductible amounts are based on our current knowledge of your health insurance plan's fee schedule and may not cover 100% of your balance. In the event there is still a balance due for co-insurance or deductible amounts, after billing your insurance, the balance is your responsibility.

WORKERS COMP/AUTO INSURANCE: We are happy to accept Workers Compensation and Auto Insurance IF you also have an individual health insurance plan. It is your responsibility as the claimant to provide us with your claim information, including adjustor name, adjustor or insurance phone & fax number and claim number or policy number, BEFORE your initial visit with us. You will be responsible for any remaining balance if your 3rd party payer denies payment for services rendered.

SELF-PAY/Time of Service Discount (TOSD): If you are uninsured or choose to not use your health insurance, we offer a cash rate of $90 for the initial visit, per current condition, and $60 for follow up visits pertaining to same current condition. If a new condition should arise, a NEW initial exam will be performed, and you will be charged the $90 initial visit rate and $60 for follow up visits for the new condition. Payment for "TOSD" rate is due at the time of service.

MISSED APPOINTMENT OR SAME DAY CANCELLATION: We require **24 hours notice** to cancel or reschedule your appointment.
To cancel:
1. Call our office: 435-210-1985
2. "Reply" to email notifications
3. Text us directly 435-210-1985

DO NOT REPLY to auto 'text' appointment reminders - they are not received for proper cancellation notification. This policy allows other patients to be treated that are awaiting an appointment slot.
Same day cancellations or missed appointments will be charged a $30 fee, not billable to your insurance.

In the event you are not able to pay outstanding balances, please let us know. Moab PT and Rehab staff can discuss other payment arrangements to allow your continued treatment at our facility. By signing below, I acknowledge I have read, understand, and hereby accept the above: Patient Financial Policies

Patient Signature_____ Date_____
(or responsible party if patient is a minor)

Printed Name of Responsible Party_____

HIPAA Privacy and Disclosure Notice

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.

Federal Law (the Health Insurance Portability and Accountability Act (HIPAA)) requires that health care providers inform patients of their rights and provide a copy to you.

YOUR HEALTH RECORD AND PROTECTED HEALTH INFORMATION

Each time you receive medical care from our practice, a record of your visit is created. This record typically includes, but is not limited to, information such as your name, age, address, a brief medical history, symptoms, any test results, the treatment provided to you, treatment plans devised for your care, and notes on follow-up care to be performed. How your health care information may be used and what control you may exercise over the use of your healthcare information is described in this Privacy Notice.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Our Practice may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless the practice has obtained your authorization or the use or disclosure is otherwise permitted by the HIPAA privacy regulations or state law. Disclosures of your protected health information for the purposes described in this Privacy Notice may be made in writing, orally, or by facsimile.

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your protected health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operation: your health information my be used as necessary to support the day-to-day activities and management of Moab Physical Therapy and Rehab. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality. Other examples might include: employee review activities, training programs including those in which students, trainees, or practitioners in health care learn under supervision, accreditation, certification, licensing or credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs, and business management and general administrative activities. In certain situations, we may also disclose patient information to another provider or health plan for their health care operations.

Law enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

OTHER USES AND DISCLOSURES FOR HEALTH CARE OPERATIONS MAY INCLUDE:

Appointment Reminders: Your health information may be used to contact you, a family member or friend involved in your health care as authorized by you as a reminder that you have an appointment for treatment or medical care at our facility. We may also leave a message on your answering machine / voicemail system unless you tell us not to.

Health Related Benefits and Services: We may use or disclose your protected health information to tell you about health related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment of Your Care: We may disclose your protected health information to a friend or family member who is involved in your medical care. We may also give information to someone assisting you in the payment for your care. We may also tell your family or friends that you are in the facility at the time of your care. If you want any of this information restricted you must communicate that to us using the appropriate procedure.

Worker's Compensation: The facility may release your health information to comply with worker's compensation laws or similar programs.

You may object to these disclosures. If you do not object to these disclosures or we can infer from the circumstances that you do not object.

Uses and Disclosures which you authorize: Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization.

INDIVIDUAL RIGHTS

Although your health record is the physical property of the healthcare practitioner or Facility that compiled it, the information belongs to you. You have certain rights under the federal privacy standards. These include: *The right to request restrictions on the use and disclosure of your protected health information; The right to receive confidential communications concerning your medical condition and treatment; The right to inspect and copy your protected health information; The right to amend or submit corrections to your protected health information; The right to receive an accounting of how and to whom your protected health information has been disclosed; The right to receive a printed copy of this notice*

Please contact our HIPAA Privacy Officer if you have questions about access to your medical record. We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

RIGHT TO REVISE PRIVACY PRACTICES: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION: You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our clinic. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

COMPLAINTS: If you would like to submit a comment or complaint about our privacy practices, please submit your concerns to:

Dr. Rhonda Cowern, DPT, Cert DN 131 E 100 S, Moab, UT 84532 phone: 435-210-1985 **INITIAL: _____**