

**RETURN PATIENT: PERSONAL INFORMATION**

PLEASE COMPLETE ALL SECTIONS that have CHANGED since last treatment:		
Full Legal Name	Home Phone	Cell Phone
Address	City	Zip Code
Email address (print clearly)	Date of Birth: _____ / _____ / _____	Last 4 digits (only) social security - _____
**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: \_\_\_\_\_  
 Parent or Guardian (if minor): \_\_\_\_\_ Date: \_\_\_\_\_

**CONSENT FOR TREATMENT:**

I hereby give permission for Moab Physical Therapy and Rehabilitation 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 to have them answered to my satisfaction. I understand that I may decline treatment at any time.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CONSENT TO RELEASE / OBTAIN MEDICAL INFORMATION:**

Permission is hereby granted to Moab Physical Therapy and Rehabilitation to release information to my insurance company, employer, attorney, workers compensation carrier, and physician or facility referred to for further treatment and/or my referring primary care physician. Permission is hereby granted to any facility where I have been treated to release medical records to Moab Physical Therapy and Rehabilitation.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**HIPAA Privacy and Disclosure Notice Reminder**

I was informed that my personal and medical information will not be shared without proper authorization:

**Initial**

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

**MEDICAL HISTORY**

<b>PLEASE COMPLETE ALL SECTIONS</b>		
Mechanism of Injury:	Injury Date: Have you had: XRAY / MRI / CT scan / other	Surgery : YES / NO Date: _____
Have you had physical or occupational therapy this year? YES / NO How did you hear about us?		How many visits?
Are you under going, or undergone any treatment for this injury? MD / Chiro / PT / Massage / Other Please Explain:		
Has your primary care physician ever warned you against exercise? YES / NO Please Explain:		
Are you currently engaged in some form of exercise? YES / NO Please Explain:	Do you currently have restrictions at work due to injury or currently unable to work? YES / NO Please Explain:	
Have you ever been diagnosed by a physician with any of the following: <input type="checkbox"/> History of Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Cardiac Disease <input type="checkbox"/> Arthritis <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Respiratory Disease <input type="checkbox"/> Chronic Fatigue <input type="checkbox"/> Epilepsy <input type="checkbox"/> Myofascial pain <input type="checkbox"/> OTHER: _____		
Have you experienced any of the following symptoms in the past few weeks to 1 month: <input type="checkbox"/> Abdominal or Chest Pain <input type="checkbox"/> Dizziness or Fainting <input type="checkbox"/> Nervousness <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Unexplained Weight Loss <input type="checkbox"/> Illness or Fever <input type="checkbox"/> Severe Fatigue <input type="checkbox"/> Loss of Balance <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Migraines/ Headache <input type="checkbox"/> Depression <input type="checkbox"/> Shortness of Breath		
Are you pregnant? YES / NO	Please list any <b>medical</b> conditions not mentioned above:	
Please list <b>all</b> current prescription <b>medications</b> :		
list <b>all</b> herbal supplements (Vitamin D, etc):		
list <b>all</b> over the counter medications (Aspirin, Advil, etc):		

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

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PLEASE PRINT NAME

**MOAB** | **PHYSICAL THERAPY &**  
**R E H A B I L I T A T I O N**

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 \_\_\_\_\_