1 Professional Plaza, Rexburg, ID. 83440
P. 208.359.2500
F. 208.359.2502

advanced PHYSICAL THERAPY & WOUND CENTER

Patient Information

TODAY'S DATE: _____ REFERRING PHYSICIAN: _____

PRIMARY CARE PHYSICIAN: _____

Patient's Name: _____ SSN#: _____

Mailing Address (*address, city, state, zip*): _____

Birth Date: _____ Marital Status: _____ (*circle one*) MALE FEMALE

Home Phone: _____ Cell Phone:_____ Appt Reminders: (circle) text/call

Employer_____Email Address_____

EMERGENCY CONTACT: _____Relationship: _____Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____

Policy Holder Name: _____ Relationship: _____ DOB: ____/____/_____

Member ID#: _____ Group #: _____

May leave blank if cards were provided *May leave blank if cards were provided*

Secondary Insurance: _____

Policy Holder Name: _____ Relationship: _____ DOB: ____/____/_____

Member ID#: _____ Group #: _____

May leave blank if cards were provided *May leave blank if cards were provided*

AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST

I request that payment of authorized insurance, a prepaid medical plan, Medicare or Medicaid benefits for me or on my behalf be made Advanced Physical Therapy & Wound Center. I authorize any holder of medical information about me to release to the insurance company and to the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable for any charge covered by any insurance. I consent to therapy services as ordered by my physician and/or as deemed necessary by a licensed physical/occupational/speech therapist of our Center.

Please sign and date:

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

By signing this document, I also acknowledge that I have read and may receive a copy of Advanced Physical Therapy & Wound Center's **Notice of Privacy Practices** (Please ask if you'd like to have a copy).

Please sign and date:

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

I have read and understand the **Financial Policies** and agree. (Please ask if you'd like to have a copy).

Please sign and date:

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

Medical History Form

NAME:_____ **DATE:** ____/____/_____

AGE: _____ **WEIGHT:** _____ **HEIGHT:** _____ **Referring Dr.** _____ **Primary Dr.** _____

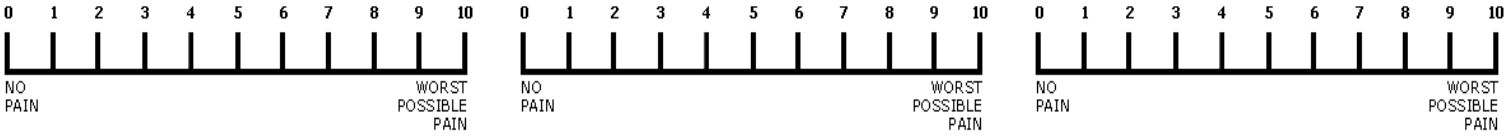
Currently receiving Home Health services or Physical Therapy at another location? ☐ Y ☐ N

1. Current Problem: _____

2. How and when did it happen: _____ ___/___/____

3. Please mark the number that best describes your pain/discomfort level:

•At worst **•Currently** **•At best**



4. Describe your pain: _____

5. What increases your pain/discomfort? _____

Decreases? _____

6. List any activities you are unable to perform as a result of your pain/discomfort/symptoms:

_____

7. Have you had surgery related to this problem? ☐ Yes ☐ No When: ____/____/____ What:_____

8. Was the onset of your pain/problem: ☐ SUDDEN ☐ GRADUAL

9. How is your general health? ☐ GOOD ☐ FAIR ☐ POOR

10. Do you have a history of falls? ☐ No ☐ Yes If yes, when was your last fall? _____

11. Are you currently taking any medications? ☐ No ☐ Yes:_____

12. Are you allergic to any medications? ☐ No ☐ Yes Please list:_____

Type of reaction: ☐ Hives ☐ Difficulty Breathing ☐ Rash ☐ Dizziness ☐ Nausea ☐ Headache ☐ Swelling

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

☐ Alzheimers	☐ Type I Diabetes	☐ Obesity	☐ Huntington's Disease	☐ Fibromyalgia
☐ Cardiovascular (Heart) Disease	☐ Type II Diabetes	☐ Stroke	☐ Immune Suppression	☐ Osteoarthritis
☐ Fracture or Suspected Fracture	☐ High Blood Pressure	☐ Depression	☐ Lupus	☐ Pacemaker
☐ Traumatic Brain Injury	☐ Cancer; Type _____	☐Anxiety	☐ Muscular Dystrophy	☐ Parkinson's Disease
☐ Rheumatoid Arthritis	☐ Current Infection	☐ Other: _____		

14. Do you smoke? ☐ Yes ☐ No Number of packs/day:_____

15. Have you recently had sudden: ☐ weight loss ☐ weight gain ☐ neither

16. Please list any special needs/concerns of which we should be aware? (i.e., vision, hearing, speech, language assistance, physical limitations, sensitivity to smell, environmental concerns):_____

_____

17. FOR WOMEN: Are you currently pregnant or think you may be pregnant? ☐ Yes ☐ No

If we are seeing you for back and neck pain:

18. Have you experienced these problems or similar problems before? ☐ Yes ☐ No

Please Explain:_____

We sincerely appreciate your choice to see us for your Therapy and Wound Care needs. Please share how you heard about us. _____

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FINANCIAL POLICY

TO OUR VALUED PATIENTS:

We are committed to providing you with the best possible care. If you have medical insurance, we are prepared to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is due on each visit for charges incurred up through your last visit. We accept cash, checks, MasterCard, or Visa. We bill electronically to expedite payment of claims. If you have an insurance that requires a paper claim to be completed, we will gladly complete and mail the claim form along with the claim for you.

Please read carefully:

1. Not all services are a covered benefit in all insurance contracts. Some insurance companies arbitrarily select certain services they will not cover. These particular services, if any, are your responsibility.

2. Medicare patients without a secondary insurance are responsible for the 20% not covered by Medicare. You will also be responsible for any deductibles that are not covered by your secondary insurance.

3. If this injury is work related, and a Workers Compensation claim has been initiated, you are given a certain number of authorized visits. We will need your Workers Compensation insurance billing information, your claim number, and your case manager's name and phone number. **If unable to provide this information, your account will be deemed as "self pay" until applicable insurance information is received by the provider from you**. In the event that your case is denied for any reason by Workers Compensation, then you are responsible for each additional visit.

4. For liability cases, where another party is responsible, you must provide us with all the billing information. If you have an attorney, please provide this information on the registration form. Any court documents that assign payment of medical services must be supplied within the first 2 weeks of your treatment.

Co-pays, deductibles, and private pay agreements are due at the time of service. Your co-pays must be kept current each week unless other arrangements are made. Allowable forms of payment are cash, checks, Visa, or MasterCard. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

I request and authorize Advanced Physical Therapy & Wound Center to file my claim form for me. I authorize my insurance benefits to be paid directly to Advanced Physical Therapy & Wound Center. I understand that I am responsible for any amount of my bill that is not covered by my insurance.

Alicia G. Siddoway PT & Associates

*Blake Galbraith DPT * Elaine Spang PTA * Stacey Holm PTA*

AdvancedPTandWound@gmail.com

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NOTICE OF PRIVACY PRACTICES

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.

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This notices summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect.

1. Uses and Disclosures We May Make Without Written Authorization. We may use or disclose your health information for certain purposes without your written authorization, including the following:

Treatment. We may use or disclose your information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; to provide appointment reminders; or to provide information about treatment alternatives or services we offer.

Payment. We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain preauthorization or payment for treatment.

Healthcare Operations. We may use or disclose your information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions affecting the practice.

Other Uses or Disclosures. We may also use or disclose your information for certain other purposes allowed by 45 CFR §164.512 or other applicable laws and regulations, including the following:

- To avoid a serious threat to your health or safety or the health or safety of others.
- As required by state or federal law such as reporting abuse, neglect, or certain other events.
- As allowed by workers compensation laws for use in workers compensation proceedings.
- For certain public health activities such as reporting certain diseases.
- For certain public health oversight activities such as audits, investigations, or licensure actions.
- In response to a court order, warrant or subpoena in judicial or administrative proceedings.
- For certain specialized government functions such as the military or correctional institutions.
- For research purposes if certain conditions are satisfied.
- In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes.
- To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.

2. **Disclosures We May Make Unless You Object.** Unless you instruct us otherwise, we may disclose your information as described below.

- To a member of your family, relative, friend, or other person who is involved in your healthcare of payment for your healthcare. We will limit the disclosure to the information relevant to that person's involvement in your healthcare or payment.
- To maintain our facility directory. If a person asks for you by name, we will only disclose your name, general condition, and location in our facility. We may also disclose your religious affiliation to clergy.
- To contact you to raise funds for Riverside Rehabilitation dba Madison Physical Therapy and Wound Center. You may opt out of receiving such communications at any time by notifying us.

3. **Uses and Disclosures With Your Written Authorization.** Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes; for most marketing purposes; or if we seek to sell your information. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

4. **Your Rights Concerning Your Protected Health Information.** You have the following rights concerning your health information. To exercise any of these rights, you must submit a written request to us.

- You may request additional restrictions on the use or disclosure of information for treatment, payment or healthcare operations. We are *not* required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item of service, and you request that information concerning such item or service not be disclosed to a health insurer.
- We normally contact you by telephone or mail at your home address, or through email if you have provided us with your email address. You may request that we contact you by alternative means or at alternative location. We will accommodate reasonable requests.
- You may inspect and obtain a copy of records that are used to make decisions about your care or payment for you care, including an electronic copy. We may charge you a reasonable cost-based fee for providing records. We can deny your request under limited circumstances, e.g. if we determine that disclosure may result in harm to you or others.
- You may request that your protected health information be amended. We may deny your request or certain reasons, e.g. if we did not create the record or if we determine that the record is accurate and complete.
- You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period.
- You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.

5. **Changes To This Notice.** We reserve the right to change the terms of this Notice at any time, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the operative Notice from our receptionist.

6. **Complaints.** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying us. All complaints must be in writing. We will not retaliate against you for filing a complaint.

7. **Contact Information.** If you have any questions about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained about, please contact us at (208) 359-2500.