WASATCH PHYSICAL THERAPY & SPORTS MEDICINE

Items marked with an asterisk are required

Patient Information:

Legal Name*:_____ Sex*: □ Male □ Female

DOB*:____/_____/_____

Social Security Number*_____-_____-_____
Marital Status: □ Married □ Single □ Divorced □Other

Home Phone : (_____) _____-_____Cell Phone: (_____) _____-_____

Work Phone: (_____) _____-_____

Email Address (Parent or Guardian)*_____

Mailing Address *:_____

City:_____ State:_____ Zip:_____
Employer:_____ □ Full □ Part

Person Responsible for payment _____
Referring Physician:_____

Insurance Provider:_____

Consent & Conditions of Admission

I hereby certify that I have read and agree to the terms listed in the Consent and Conditions of Admission

Signature*:_____Date:_____

Patient Consent to the use and disclosure of health information for treatment, payment, or health department

I hereby certify that I have read and agree to the terms listed in the HIPPA Release

Signature*:_____ Date:_____

WASATCH PHYSICAL THERAPY & SPORTS MEDICINE

No-Show/Cancellation Policy

Our goal is to provide quality health care to all our patients in a timely manner. No shows, late arrivals, and cancellations inconvenience not only our providers, but our other patients as well. Please be aware of our policy regarding missed appointments.

As a courtesy, and to help patients remember their scheduled appointments, Wasatch Physical Therapy sends text message and email reminders upon scheduling, 1 day, and 3 hours in advance of the appointment time.

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule, please give us at **least 24 hours notice**. If you do not cancel or reschedule your appointment with at least 24 hours notice, we may assess a **$40 fee for late cancellation** appointments or **$75 "no show"** service charge to your account/card on file. The late cancellation and no show service charge is not reimbursable by your insurance company. You will be billed directly for it.

After two consecutive no-shows to your appointment, our practice may decide to terminate its relationship with you.

Account Type (check one): Visa____ MasterCard____ AMEX____ Discover____

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV2 (3-digit number on back of Visa/MC, 4 digits on front of AMEX) _____

Billing Zip-code _____

I understand the Cancellation/No-Show policy of Wasatch Physical Therapy and agree to provide a credit card number, which may be charged for any late cancellation or no-show of a scheduled appointment. I understand that I must cancel or reschedule any appointment at least 24 hours in advance to avoid a potential charge to the credit card provided.

I understand if a credit card number is not provided I will still be responsible for any and all fees.

Signature _____ Date _____

WASATCH PHYSICAL THERAPY & SPORTS MEDICINE

Insurance & Workers Comp Information

******Please Note Co-Payments are Due at the Time of Service*

Primary Insurance Carrier*: _____

Name of Insured*: _____

Insured Date of Birth* ____/____/_____

Relationship to Patient:_____ Member ID#*_____ Group#_____

Secondary Insurance Carrier:_____

Name of Insured:_____ Insured Date of Birth*____/____/_____

Relationship to Patient:_____ Member ID# _____ Group#_____

Is this injury work related: ____Yes ____ No.

Is this a Workers Compensation Claim? ___Yes ___No

If Yes Fill Out the Info Below.

Claim#_____

Employer: _____

Adjuster Name: _____ Phone#_____

Is this Auto Related: _____ Yes _____ No

Name of Auto Carrier:_____

Phone#_____ Policy# _____

Date Of Accident:____/____/_____

Referring Physician: _____

Phone#_____

Consent and Conditions of Admission

As either the patient or the legally authorized representative of the patient, the following consents, understanding, and agreements are made on my own behalf or on behalf of the patient in partial consideration of the health care services to be provided to the patient in the facility.

1) **Consent of Services**: On behalf of the patient, consent is hereby given to the facility, its medical staff, and employees to provide facility and other health care services to patient and to administer physician orders for the benefit of the patient. Itis understood that there is a risk of substantial and serious harm involved in such facility and health care services, and such risk is accepted in the hope of obtaining beneficial results from such services. It is understood the Physical Therapists are separately responsible to explain what they do and, in some cases, to obtain separate consent for some of the services they perform. It is understood that now and, in the future, the patient's condition and the health care services; all such questions, if any, have been satisfactorily answered. No promises of any particular outcome or successful result have been made, it being understood and accepted that there is some uncertainty involved in the facility and health care services for which this consent is given.
2) **Miscellaneous Agreements and Understandings**:
   a) **Medical Education**: Permission is given for observers involved in medical training and education to be present when tne-pat1ent - received health care services.
   b) **Personal Property:** It is understood that the facility is not responsible for personal property.
   c) **Release of Information**: The law requires Wasatch Physical Therapy & Sports Medicine to make and keep records of your medical treatment. Wasatch Physical Therapy & Sports Medicine safeguards those records. Access to medical records is limited to persons who are providing, coordinating, evaluating, or improving health care, subject to applicable law. By receiving services at Wasatch Physical Therapy & Sports Medicine and its employees, you agree to the release of medical record information for the uses specified above, and for release to insurance companies or other third parties to assist in paying your health care costs.
   d) **Assignment of Benefits**: Any and all benefits from insurance companies, other companies, and other third party payers that are payable to patient or on behalf of patient for health care services and related payment for services rendered or provided to patient are hereby transferred and assigned to facility for the exclusive purpose of paying for charges associated with health care services provided directly to patient in the facility. Itis understood and intended that all insurance companies and other third-party payers will pay benefits directly to facility in payment of facility's charges and the charges of any other health care providers for whom facility is authorized to bill in connection with health care services provided to patient.
   e) **Financial Responsibility**: Patient and the undersigned, if other than the patient, each jointly and severally agree to pay for all the health care services rendered to patient in the facility including but not limited to any amounts not paid by any insurance company or other third-party payer. Patient and the undersigned, if other than the patient, remains responsible for all co-payments, deductible, coinsurance and/or non-covered services regardless of amount paid by insurance of their party payer. It is understood and agreed that charges not paid in a timely fashion may be placed for collection or with an attorney for purposes of collection. It is further understood and agreed by the patient and the undersigned that any amounts not paid within 30 days of the date of the facility's bill or statement for payment shall accrue interest at the rate of 1½% per month(18% per year) on the unpaid balance. In the event that any unpaid balance is placed for collection or with an attorney for collection, patient and the undersigned, if other than the patient, each jointly and severally agree to pay costs and a reasonable attorney's fee in connection with the collection process. A service charge of$15.00 may be collected in connection with any check or other instrument rendered by me but returned unpaid to the facility.
   f) **Medicare/Medicaid Patient's Certification**: I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers or the State any information needed to process a claim for this or any related service. I request that payment of authorized charges be made in my behalf directly to the facility for its charge and for any charges of Physical Therapists or other providers for whom the facility is authorized to bill in connection with its service.
   g) **CHAMPUS/CHAMPV A Authorization**: I request payment of authorized benefits to the facility on my behalf for any services furnished me by the above named facility. I authorize any holder of medical or other information about me to release to undersigned signs this document either as the patient or as the agent representative of the patient authorized to execute this document and to accept and agree to its terms on behalf of the patient. I have read the foregoing and have had the opportunity to ask any questions I may have about the foregoing. Such questions have been answered to my satisfaction, and I understand what I am agreeing to by signing. I understand that I am entitled to request and obtain a copy of this document.

Signature Required on first page

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations (HIPPA Release)

I, the undersigned, understand that as a part of my health care, Wasatch Physical Therapy & Sports Medicine originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communications among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Wasatch Physical Therapy & Sports Medicine is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations. I further understand that Wasatch Physical Therapy & Sports Medicine reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Wasatch Physical Therapy & Sports Medicine change their notice, they will send a copy of any revised notice to the address I've provided (Either by U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health insurance:

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

Signature Required on first page

PAST MEDICAL HISTORY FORM

Patient Name: _____ DOB:_____ Date: _____

Are you presently working? ☐ Yes ☐ No Referring Physician_____ Date of next physician's visit: ___/___/___

Date of injury or onset: ___/___/___ Have you ever had physical therapy for theses symptoms before? ☐ Yes ☐ No

Check which apply to your symptoms:

☐ work related injury ☐ recurrence of previous injury
☐ motor vehicle accident ☐ injury related to lifting ☐ injury related to falling
☐ cause unknown ☐ athletic / recreational injury ☐ other: _____

Have you had a related surgery? ☐ Yes ☐ No

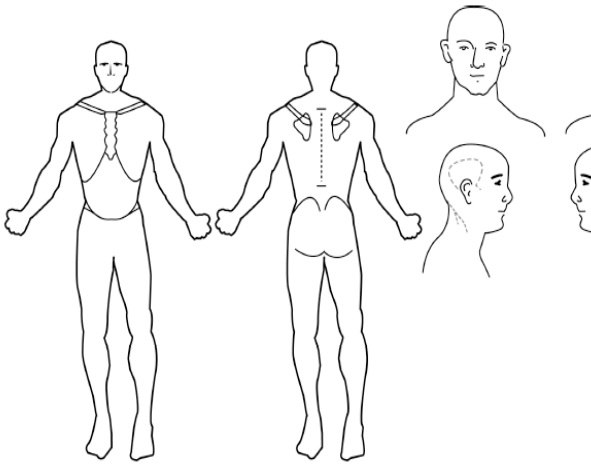
Do you have, or have you had any of the following?

	Yes	No		Yes	No
Diabetes	☐	☐	Allergies to Aspirin	☐	☐
Chest / Angina	☐	☐	Allergies to Heat	☐	☐
High Blood Pressure	☐	☐	Allergies / Poor tolerance to Cold	☐	☐
Heart Disease	☐	☐	Other Allergies	☐	☐
Heart Attack	☐	☐	Hernia	☐	☐
Heat Palpitations	☐	☐	Seizures	☐	☐
Pacemaker	☐	☐	Metal Implants	☐	☐
Headaches	☐	☐	Dizziness / Fainting	☐	☐
Kidney Problems	☐	☐	Recent Fracture	☐	☐
Are you pregnant?	☐	☐	Surgeries	☐	☐
Cancer	☐	☐	Skin Abnormalities	☐	☐
Osteoporosis	☐	☐	Sexual Dysfunction	☐	☐
Nausea/ Vomiting	☐	☐	Smoker?	☐	☐
Ringing in your ears	☐	☐	Asthma / Breathing Difficulties	☐	☐
Rheumatoid Arthritis	☐	☐	Liver / Gallbladder Problems	☐	☐
Special Diet Guidelines	☐	☐			

Please indicate below where your symptoms are located:

If yes on any of the above, please briefly explain and give approximate date:

Is there any other information regarding your past medical history that we should know about? i.e. Surgery, X-Ray, MRI, other Imaging…



Are you presently taking Medication? ☐ Yes ☐ No

If yes, please list what medications and for what condition:

Do you participate in any sports, exercise programs or activities on a regular basis? ☐ Yes ☐ No

If yes, please describe _____

Does your current injury affect your performance in these activities? If yes explain:

_____

What improves your symptoms?_____

If you are having pain, please rate the intensity of your pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain possible: _____.

_____ ____/____/____ _____

Patient's Signature Date Signature of Guardian if patient is a minor