

<b>PATIENT INFORMATION</b>		<b>Today's Date:</b>	
First Name:	Last Name:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Address:	City:	State:	Zip:
Physical address if PO Box:			
Home Phone: ( )	Work Phone: ( )	Mobile Phone: ( )	
e-mail address:			
SSN:	Birth Date:		
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widow <input type="checkbox"/> Other			
Emergency Contact:	Home Phone (if different from above): ( )		
	Mobile Phone: ( )		

<b>EMPLOYER INFORMATION</b>			
Employer's Company Name:			
Employer's Address:	City:	State:	Zip:
Phone #:	Work Status: <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Light duty <input type="checkbox"/> Off until recovered		

<b>INJURY / PAIN INFORMATION</b>	
Date of Onset:	Date of Last Physician Visit:
Type of Injury: <input type="checkbox"/> Work <input type="checkbox"/> Auto <input type="checkbox"/> Other accident <input type="checkbox"/> No specific injury	
Referring Physician:	Attorney Name:

<b>DIAGNOSED MEDICAL CONDITIONS</b>	
<input type="checkbox"/> Diagnosed High Blood Pressure	<input type="checkbox"/> Memory Loss
<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Limb Amputation
<input type="checkbox"/> Dementia	<input type="checkbox"/> Chronic Obstructive Pulmonary Disease
<input type="checkbox"/> Depressive Disorder NEC	<input type="checkbox"/> Chronic Ulcer of the Skin
<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Persistent Mental Disorders
<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Encephalitis, Myelitis
<input type="checkbox"/> Heart Disease- What type _____	<input type="checkbox"/> Congestive Heart Failure
<input type="checkbox"/> Venous Embolism and Thrombosis	<input type="checkbox"/> Cancer: Type _____
<input type="checkbox"/> Rheumatoid Arthritis	
<input type="checkbox"/> Difficulty Walking	
Place a <input checked="" type="checkbox"/> next to all that apply.	
Is there any chance you could be pregnant? _____ Yes _____ No	
Do you smoke? _____ Yes _____ No	
Do you drink alcohol? _____ Yes _____ No _____ Occasionally	

## ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of Idaho Spine & Sports **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

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**X**

**Patient's / Guardian's Signature**

**X**

**Date**

If not signed by the patient, please indicate your relationship to the patient (e.g., spouse).

**Relationship**

**Witnessed by**

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### INTERNAL USE ONLY

If the patient or representative refuses to sign this form, document the date and time the notice was presented and sign below.

Presented on (date and time)

Signature of Deliverer

**CONSENT FOR CARE AND TREATMENT**

I, undersigned, agree and give my consent for Idaho Spine & Sport Physical Therapy to furnish physical therapy care and treatment as considered necessary and proper in the diagnosis and treating my illness or injury.

**BENEFIT ASSIGNMENT / RELEASE OF INFORMATION**

I request that payment of authorized benefits be made on my behalf to Idaho Spine & Sport Physical Therapy for physical therapy services furnished to me. I authorize any holder of medical information about me to release to my insurance(s) (the "Centers of Medicare and Medicaid Services", formerly the "Health Care Financing Administration" and its agents for Medicare patients) any information needed to determine these benefits or benefits for related services.

*We ask that you provide your insurance information to us on your initial visit. This includes Primary and Secondary (if applicable) insurance information. In order to remit claims, and receive payment in a timely manner, your secondary insurance **will not** be billed if the information is not provided to us during your initial visit. It will be your responsibility to re-coup funds from the secondary carrier*

**CANCELLATION / NO SHOW POLICY**

I, undersigned, agree to **call at least 24 hours prior to a scheduled appointment to cancel** or re-schedule if needed. Allowances will be made in cases of extenuating circumstances. If you fail to cancel or show up for a scheduled appointment, you agree to pay a **\$40.00 charge**. This will be billed directly to you and is separate from your physical therapy bill.

**FINANCIAL POLICY STATEMENT (Does not apply to Medicare or Medicaid)**

. We bill your insurance company solely as a courtesy to you. We recommend you pay your estimated share or co-pay on each visit. If your insurance carrier does not make payments within 60 days, you agree to begin making monthly payments with a minimum payment of 10% of your outstanding balance or \$25 whichever is greater. After 60 days, a daily accrual rate of .055% of your outstanding balance will be applied to your balance and compounded monthly (This is a 20% annual interest rate). You may arrange a payment plan upon request. In the event that your insurance company requests a refund of payment made, you will be responsible to pay this amount.

If any payment is made directly to you for services billed by us, you agree to promptly remit same to Idaho Spine & Sport Physical Therapy.

The above does not apply to those patients who receive Worker's Compensation benefits. However, if you are denied Worker's Compensation benefits, you agree to pay the total amount of charges for services rendered to you under the same provisions as listed above.

I understand and agree that if I fail to make regular payments as described above, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

**I have read, understand and agree to the above conditions.  
I understand my full responsibility for the payment of my account**

X \_\_\_\_\_  
Patient / Guardian Date

X \_\_\_\_\_  
Idaho Spine & Sport Physical Therapy Witness Date

# Pain / Injury Questionnaire

Name: \_\_\_\_\_

• Was this from an injury?  No  Yes, describe your condition: \_\_\_\_\_

• How long have you had your current symptoms or when was your injury? \_\_\_\_\_

• Are you employed?  Yes, full time  Yes, part time  No, unemployed  No, retired

If you are employed, please fill in the following box:

- Have you lost work due to your current problem?  No  Yes, last day worked? \_\_\_\_\_
- Were you injured on the job?  No  Yes
- If working, list 2-3 specific activities that are difficult to do because of your current condition.  
If not working, list 2-3 specific activities that you anticipate being difficult when you return.
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- If not working, when do you expect to return to work? \_\_\_\_\_

• Apart from work, list 2-3 specific daily activities that are difficult because of your current condition.

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

• Do you feel your symptoms are  improving  worsening  not changing?

• Rate your pain between 0 - 10

pain level NOW \_\_\_\_\_  
 WORST pain over last 24 hours \_\_\_\_\_  
 BEST over last 24 hours \_\_\_\_\_

0 = no pain  
 3 = your pain restricts mobility or range of motion  
 8 = you would go to the hospital  
 10 = worst pain imaginable

• Have you had similar problems before?  No  Yes, Number of previous episodes:  1-5  6-10  11+  
 Year of first episode: \_\_\_\_\_

• What treatments have you tried? \_\_\_\_\_

• Does your pain wake you up at night?  No  Yes

• Have you had an  x-ray  MRI  CTscan  Injection?

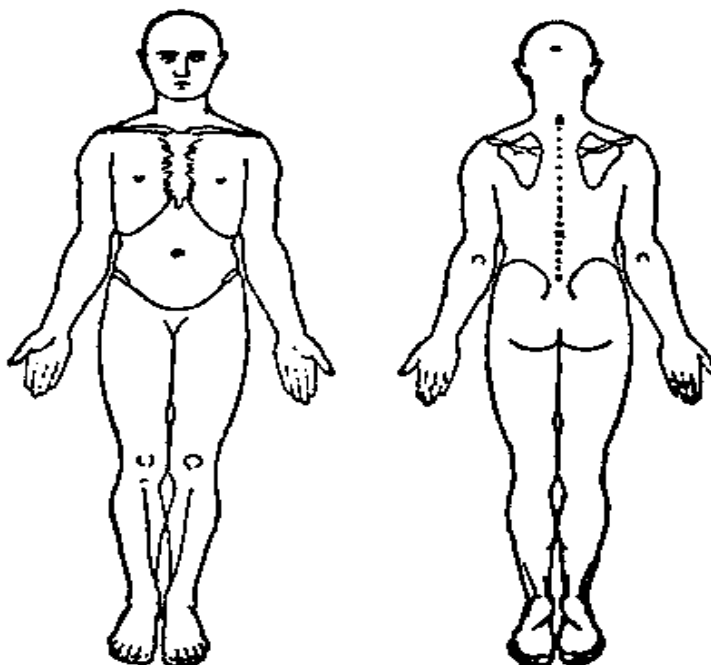
• Have you experienced recent unexplained weight loss?  No  Yes

• List 2 realistic goals you would like to accomplish while in physical therapy (please be specific)?

- \_\_\_\_\_
- \_\_\_\_\_

• Please draw your symptoms:

- ✕ = Pain
- //// = Spasm / Tightness
- ..... = Numbness / Tingling



***I attest that the information on this page is accurate.***

X \_\_\_\_\_  
**Signature** \_\_\_\_\_ **Date**