Welcome

We look forward to helping you meet your rehabilitation needs.
To help us serve you more efficiently, please review, sign, and date in the designated areas.

EVALUATION DATE	CLINICIAN	PATIENT'S NEW ACCOUNT NUMBER	PATIENT'S PRIMARY INS/SECONDARY INS

PATIENT INFORMATION

PATIENT NAME (Last, First, Middle Initial)	SSN (Social Security Number)	DOB (Date of Birth)
MARITAL STATUS ☐M(Married) ☐S(Single) ☐D(Divorced) ☐ W(Widow)	SEX ☐M(Male) ☐F(Female)	EMAIL ADDRESS
STREET ADDRESS (Mailing Address)	CITY, STATE, ZIP	DAYTIME PHONE
WORK PHONE	WHEN WAS YOUR LAST PHYSICIAN VISIT (Date)	REFERRING PHYSICIAN'S NAME
WAS THIS AN AUTO ACCIDENT? ☐Y (Yes) ☐N (No)	WORK RELATED ACCIDENT? ☐Y(Yes) ☐N(No)	DATE OF THE ACCIDENT?
ATTORNEY'S NAME & CONTACT INFORMATION (if applicable)	TELL US ABOUT YOUR INJURY	
EMERGENCY CONTACT	RELATION TO YOU?	PHONE NUMBER

What source below was the PRIMARY influence in your decision to choose Wright Physical Therapy?

Please provide added detail on the blank line below all choices (example - name of Physician, channel of TV ad, location of billboard, etc.)

☐ **PHYSICIAN** ☐ **ALLIED HEALTH PROFESSIONAL (DENTIST,HOME HEALTH,ETC.)** ☐ **PUBLIC RELATIONS EVENT** ☐ **EMPLOYER**

☐ **FRIEND/FAMILY MEMBER** ________________ ☐ **INSURANCE** ☐ **WEBSITE** ☐ **COMMUNITY EVENT** ☐ **TELEVISION** ☐ **BILLBOARD**

☐ **PHONE BOOK** ☐ **NEWSPAPER** ☐ **RADIO** ☐ **WEBSITE** ☐ **GOOGLE** ☐ **YELP** ☐ **EMAIL** ☐ **OTHER:**________________________

DETAILS:

RESPONSIBLE PARTY

RESPONSIBLE PARTY NAME OR BUSINESS NAME (IF OTHER THAN SELF)	PHONE
ADDRESS (City, State, Zip)	RELATION TO THE PATIENT
INSURED PARTY'S SSN (Social Security Number)	INSURED PARTY'S DOB (Date of Birth)

RESPONSIBLE PARTY EMPLOYER

EMPLOYER'S NAME	EMPLOYER'S ADDRESS (City, State, Zip)	EMPLOYER'S PHONE

PATIENT OR SPOUSE EMPLOYER

EMPLOYER'S NAME	EMPLOYER'S ADDRESS (City, State, Zip)	EMPLOYER'S PHONE

CONSENT FOR CARE AND TREATMENT

I, undersigned, do hereby agree and give my consent for Wright Physical Therapy to furnish medical care and treatment to myself/ ___________________________ (name if minor) as considered necessary and proper in diagnosing or treating his/her physical and condition.

____
Patient or Parent/Guardian Initials

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, undersigned, do hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payers to Wright Physical Therapy. A photocopy of the assignment is to be considered as valid as the original. I, the undersigned, do hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

____
Patient or Parent/Guardian Initials

FINANCIAL POLICY STATEMENT

The financial policy of Wright Physical Therapy is as follows:

· It is REQUIRED that your ESTIMATED patient responsibility be paid in full each week unless other arrangements are authorized.
· We bill your insurance carrier as a courtesy to you.
· If your insurance carrier does not remit payment within 60 days, you may be required to pay the balance due in full and would be entitled to a refund when the insurance carrier does remit payment.
· In the event your insurance carrier requests a refund of payments made, you will be RESPONSIBLE for the balance due on your account, created by the refund.
· If your insurance carrier pays you directly for services billed by Wright Physical Therapy, you recognize an obligation to promptly remit the same to our office.
· Please be advised that if you claim Workers Compensation benefits and are subsequently denied such benefits, you will be RESPONSIBLE for the total account balance.
· All returned checks will be charged a $20 return check charge.

NOTE: Estimates shown on the Patient Financial Agreement are ESTIMATES and are provided as a courtesy to you, but it is not intended to release you from total responsibility for your account balance. You are ultimately responsible for the account balance.

I understand and agree that my account if paid within 90 days of my discharge will be interest free, after 90 days my account will be subject to a 12% interest (APR). If I fail to make any payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting the balances due, including but not limited to court costs, collection agency fees, and attorney fees.

I UNDERSTAND THE INFORMATION ABOVE AND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

____
Patient or Parent/Guardian Initials

____ ____
Patient or Parent/Guardian Signature Print Name

________/_________/_________
Date

Acknowledgement of Receipt of Notice of Privacy Practices

A. I have received a copy of Wright Physical Therapy's Notice of Privacy Practices.	Yes	No
B. I agree to the open treatment area used by Wright Physical Therapy. All evaluations are done in a private area.	Yes	No
C. I agree and understand that other patients will be completing treatment plans during my visit and may overhear information regarding my plan of care.	Yes	No
D. I agree that a Physical Therapist/Physical Therapist Assistant student may assist in my care.	Yes	No
E. I agree that I must sign in and sign out at each visit and understand that subsequent visitors may have the opportunity to see my name.	Yes	No
F. I agree that Wright Physical Therapy employees may contact me by phone in regard to my health status.	Yes	No
G. I agree to abide by Wright Physical Therapy's policy that, for safety reasons, only patients are allowed in the treatment area unless prior authorization is obtained from the physical therapist.	Yes	No
H. Are you currently receiving any type of nursing, professional assisted care, occupational therapy, or physical therapy at your home? Outside of family members, do you have anyone coming into your home to assist with things such as medications or personal care (dressing, bathing, etc.)?	Yes	No

Patient or Parent/Guardian signature ____

_________/__________/_________
Date

THIS SECTION IS FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited obtaining the acknowledgement
- ☐ An emergency prohibited obtaining the acknowledgement
- ☐ Other (please specify):____

Authorized WPT Representative's Signature

Please Print Name

_________/_________/_________
Today's Date

PATIENT MEDICAL HISTORY

Name: ____ Family Physician: ________________________________

Date of 1st MD visit for this injury: __________________ Referring Physician: ______________________________

Have you had surgery for this injury? YES NO

Type of Surgery: _______________Date: ________

Please list all prescription and non-prescription medication you are currently taking:

Please check and date any of the following Medical services for *this* Injury/Episode:

- ☐ Orthopedist
- ☐ Neurologist
- ☐ General Practitioner
- ☐ Physical Therapist
- ☐ Podiatrist
- ☐ Occupational Therapist
- ☐ Chiropractor
- ☐ Other ______________________________

- ☐ X-Rays ______________________________
- ☐ MRI ______________________________
- ☐ CT Scan ______________________________
- ☐ Emergency Room Care ______________________________
- ☐ EMG / NCV ______________________________
- ☐ Myelogram ______________________________
- ☐ Massage Therapy ______________________________

Do you now have or have you ever had any of the following:

	Start Date (Month/Year)		*Start Date (Month/Year)*		*Start Date (Month/Year)*
☐ Asthma, Bronchitis, or Emphysema	____/____	☐ Osteoporosis	____/____	☐ Neck Injury	____/____
☐ Shortness of Breath	____/____	☐ Gout	____/____	☐ Neck Surgery	____/____
☐ Chest Pain / Angina	____/____	☐ Sleep Disorders	____/____	☐ Shoulder Injury	____/____
☐ Coronary Heart Disease	____/____	☐ Emotional / Psychological Problem	____/____	☐ Shoulder Surgery	____/____
☐ Pacemaker	____/____	☐ Bowel and/or Bladder Dysfunction	____/____	☐ Elbow / Hand Injury	____/____
☐ High Blood Pressure	____/____	☐ Severe or Frequent Headaches	____/____	☐ Elbow / Hand Surgery	____/____
☐ Heart Attack or Heart Surgery	____/____	☐ Vision or Hearing Difficulties	____/____	☐ Back Injury	____/____
☐ CVA (Stroke) / TIA (Mini Stroke)	____/____	☐ Dizziness or Fainting	____/____	☐ Back Surgery	____/____
☐ Blood Clot / Emboli	____/____	☐ Numbness or Tingling	____/____	☐ Knee Injury	____/____
☐ Epilepsy / Seizures	____/____	☐ Weakness	____/____	☐ Knee Surgery	____/____
☐ Thyroid Dysfunction / Goiter	____/____	☐ Unexplained Weight or Energy Loss	____/____	☐ Leg/Ankle/Foot Injury	____/____
☐ Anemia	____/____	☐ Hernia	____/____	☐ Leg/Ankle/Foot Surgery	____/____
☐ Infectious Diseases	____/____	☐ Varicose Veins	____/____	☐ Are you Pregnant?	____/____
☐ Diabetes	____/____	☐ Allergies	____/____	☐ Do you Smoke?	____/____
☐ Cancer / Chemotherapy / Radiation	____/____	☐ Any Pins or Metal Implants	____/____		
☐ Arthritis / Swollen Joints	____/____	☐ Joint replacement	____/____		

Please provide us with any other information that would assist us in your care: ______________________________

____

What are your expectations while in this program? ______________________________

Patient or Parent/Guardian Signature: ______________________________ **Date:** ______________

Patient Attendance Policy

Attendance to Physical Therapy is important to your recovery. We take it seriously and want you to as well. Your referring doctor and/or therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is the most important aspect of a plan of care. Your requirement, besides attending your visits, is to follow your therapist's instructions. This second requirement cannot be met unless you consistently arrive to the clinic at your appointed time. If during your treatment, you cancel or do not appear for an appointment 3 times, you may be discharged until your circumstances allow you to be more consistent with therapy. We will contact you up to three times to attempt to get you back on the schedule for your treatment.

- If you are sick, please call by 9 A.M. to avoid a $20 cancellation fee.
- If you need to change or miss an appointment, please give a 24-hour notice to avoid a $20 cancellation fee.
- If you are late for your appointment, it may be shortened or cancelled at our discretion.

Thank you for actively participating in your care.

Please sign that you have read and understand our Attendance Policy. A copy of this policy is available upon request.

Patient Signature Date

Wright
PHYSICAL THERAPY
JOINT • SPINE • SPORT

NOTICE OF PRIVACY PRACTICES - Patient Copy

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 14 April 2008, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and applicable law permits the terms of this Notice at any time, provided such changes. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. Wright Physical Therapy utilizes an open treatment facility. It is possible that while under our care an unauthorized individual may have access to your protected health information via overheard verbal communications. We will do everything possible to protect your rights to privacy and confidentiality. During your care we also ask that you sign in each visit, subsequent patients will have the opportunity to read the names of those signed in before them.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in the Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to

the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.
Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose, to authorized federal officials, health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $ .10 (ten cents) for each page, $15.00 (Fifteen dollars) per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communications: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **(You must make your request in writing.)** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.
Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, contact us at:

TWIN FALLS
1444 Falls Ave. E.
Twin Falls, ID 83301
208-736-2574
Fax 208-736-2594

TWIN FALLS CHENEY
452 Cheney Dr W #190
Twin Falls, ID 83301
208-329-7667
Fax 208-329-7669

KIMBERLY
931 Center Street
Kimberly, ID 83341
208-423-9999
Fax 208-423-9998

BURLEY
1945 Hiland Ave.
Burley, ID 83318
208-647-0224
Fax 208-647-0239

JEROME
111 Pioneer Court
Jerome, ID 83338
208-944-9277
Fax 208-944-9280

WENDELL
280 West Main St.
Wendell, ID 83355
208-944-4003
Fax 208-944-4757