High Desert Physical Therapy
820 W. Chubbuck Rd.
Chubbuck, ID 83202

Jared Pugmire, DPT
Bryan Lawson, DPT
Phone. 208-240-6017
Fax 208-240-6023

PATIENT INFORMATION FORM

Name (last, first, middle)_____DOB_____

If patient is a minor, parent or legal guardian _____

Street Address_____ City _____State_____ Zip_____

Social Security # _____-_____-_____ Phone (h) _____ Cell_____

How would you like to be reminded of your appointments? Text Email Phone None

Male _____ Female _____ Married_____ Single_____ Widow_____

Email Address_____

Emergency contact:_____ Phone_____

Your Employer_____ Phone _____

Referring Doctor _____Primary Care Physician _____

Who can we thank for sending you our way?_____

Do you have a pacemaker? YES NO

Have you RECENTLY noted any of the following (check all that apply):

Fatigue	Muscle Weakness	Fever/Chills/Sweats	Diarrhea
Heartburn	Shortness of Breath	Weight Loss/Gain	Fainting
Cough	Nausea/Vomiting	Difficulty Swallowing	Headaches
Constipation	Numbness/Tingling	Dizziness/Lightheadedness	

Have you EVER been diagnosed with any of the following conditions (check all that apply):

Cancer	Depression	Asthma	High Blood Pressure
Stroke?TIA	Anemia	Diabetes	Tuberculosis
Osteoporosis	Incontinence	Gout	Bladder/UTI
Osteoarthritis	Epilepsy	GERD	Thyroid Problems
Heart Disease	Hepatitis	Blood Clots / DVT	Emphysema/Bronchitis

Arthritis (Rheumatoid, Psoriatic)

FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO

Other medical conditions/major injuries that we should be aware of:_____

Do you have any allergies? (ie. Latex, lotions, etc.)_____

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):_____

_____

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PAYMENT AUTHORIZATION

Assignment of Insurance Benefits

_____ Initials

I authorize that the payment of my insurance benefits be made directly to High Desert Physical Therapy for any services that are reimbursable by Medicare, Medicaid or any third party payers.

Guarantee of Payment

I understand that all payments designated as "the patients responsibility" are due and payable at the time of service or billing. I guarantee that I will pay:

_____ Initials

My designated portion including co-pays/co-insurance and my deductible

_____ Initials

All amounts due for services that my insurance company has stated are not covered benefits (**IF** I have been advised by High Desert Physical Therapy in advance of the service delivery and have authorized it in writing)

_____ Initials

All amounts due for services billed by High Desert Physical Therapy but paid directly to me

_____ Initials

All amounts due for services billed by High Desert Physical Therapy to a Workers' Compensation payor which was subsequently declared by my employer to be a non-eligible claim

_____ Initials

All amounts due for claims submitted by High Desert Physical Therapy to my insurance company and not paid by 60 days

Medicare and Workers Compensation Information

_____ Initials

I certify that the information I have provided to High Desert Physical Therapy for payment under the Social Security Act (Medicare) or under the Workers Compensation Program is correct, including but not limited to any related accidents/illness or other insurers/payers available.

Cancellation

_____ Initials

I acknowledge that 24-hour notice will be given to cancel an appointment when foreseeable. High Desert Physical Therapy has the discretion to charge a fee of $50 for repeated "no call, no show" appointments.

I, _____, understand the statements I have authorized above and declare their truthfulness
Printed Name

_____ _____
Patient or Authorized Representative for Patient Signature Date

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CONSENT FOR PURPOSES OF TREATMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information of High Desert Physical Therapy, LLC (HDPT) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of High Desert Physical Therapy, LLC. I understand that diagnosis or treatment of me by Jared Pugmire, DPT or one of his staff may be conditioned upon my consent as evidenced by my signature on this document. My signature of this letter of consent signifies that I will actively participate in the plan of care discussed with me by the therapist unless I verbally notify the therapist otherwise.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operation of the practice. HDPT is not required to agree to the restrictions that I may request. However, if HDPT agrees to a restriction that I request, the restriction is binding on HDPT, Jared Pugmire, DPT, and his staff.

I have the right to revoke this consent, in writing, at any time, except to the extent that Jared Pugmire, DPT, or HDPT has taken action in reliance on this consent.

My “Protected Health Information” means health information, including my demographic information collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe that information may identify me.

I understand I have a right to request and review a copy of HDPT’s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of HDPT. This Notice of Privacy Practices also describes my rights which I understand and HDPT’s duties with respect to my protected health information.

I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent to me in the mail or asking at the time of my next appointment.

Patient or Authorized Persons:

_____

Patient name

_____ _____

Signature *Date*

Patient Health Questionnaire - PHQ

ACN Group, Inc. Form PHQ-202

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

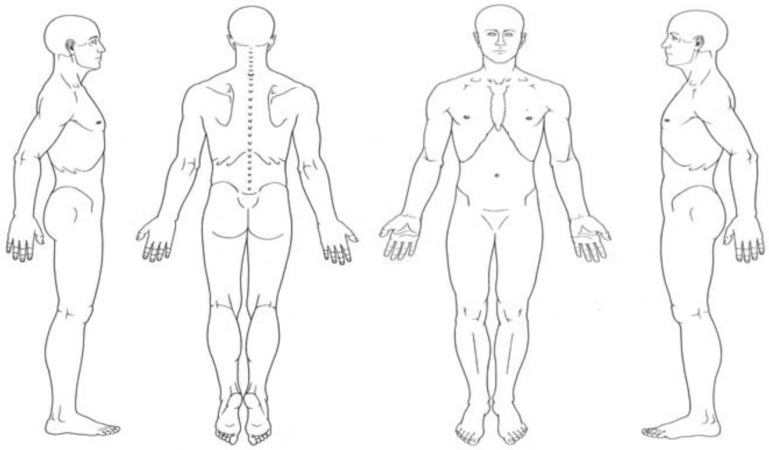
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ *Unbearable*

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

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8. Who have you seen for your symptoms?

① No One
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

_____

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature _____ **Date** _____