Rehab Specialists OF IDAHO

Occupational, Physical & Speech Therapy

Patient's Name:_____ Date of Birth:_____

Physical Address:_____ City/State:_____ Zip:_____

Mailing Address:_____

Phone Number:_____ Place of employment:_____

Emergency contact and phone number:_____

Social Security Number:_____

Primary Care Provider:_____ Referring Physician:_____

Insurance Information

___ By initialing, I give consent to Rehab Specialists of Idaho to provide occupational, physical, and/or speech therapy (evaluation and any further recommended intervention). I understand and agree that, (regardless of my insurance status), that I am ultimately responsible for the balance of my account for any services rendered. I have read all the information contained on this form and have completed the above measures. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information. I agree to notify Rehab Specialists of Idaho if I have previously seen another physical, speech or occupational therapist or if I see another therapist during my treatment with Rehab Specialists of Idaho. If I do not notify Rehab Specialists of Idaho, I agree to pay for any unauthorized services that are not paid by my insurance. I authorize Rehab Specialists of Idaho to release my records to their billing service, my insurance company and my physician. I understand that these records will be held in strict confidence and will not be released to any unauthorized person. I authorize payment of medical benefits to undersigned physical or supplier of services rendered.

Insurance company:_____ Policy number:_____

Group number:_____

Secondary Insurance:_____ Policy number:_____

Group number:_____

Notice of Privacy Practices

I, _____ date_____ do herby consent and acknowledge my agreement to the terms set forth in the Privacy Policy and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward. Notice of Privacy Practices is posted and available upon request.

In accordance with the team approach we take to client care at Rehab Specialists of Idaho, your therapist(s) will periodically consult with other members of the RSI team regarding your case and treatment in order to provide the best care possible. By signing this privacy practice notice, you are giving your permission for this case collaboration to occur. Please consult with your/your child's therapist or the compliance officer if you have questions or concerns.
Additionally, you are also authorizing us to utilize the emergency contact you provide if we are unable to reach you via the contact numbers in your intake paperwork (if the number provided are not in service). We will only disclose who we are, that we are attempting to contact you for therapy needs, and that they were listed as an emergency contact for the patient in question.

Present/Past History

Are you currently receiving therapy services at another clinic? Yes / No If yes, which clinic:_____

Have you had OR do you presently have any of the following conditions? (Check if yes.)

___ Rheumatic fever
___ Recent operation
___ Edema (swelling of ankles)
___ High blood pressure
___ Heart attack
___ Low blood pressure
___ Seizures
___ Known heart murmur
___ Fainting or dizziness with or without physical exertion
___ Diabetes
___ High cholesterol
___ Injury to back or knees
___ Nocturnal dyspnea (shortness of breath at night)
___ Chest pains
___ Lung disease
___ Intermittent claudication (calf cramping)
___ Unusual fatigue or shortness of breath with usual activities
___ Temporary loss of visual acuity or speech, or short-term numbness or weakness in one side, arm, or leg of your body
___ Orthopnea (the need to sit up to breathe comfortably) or paroxysmal (sudden, unexpected attack)
___ Palpitations or tachycardia (unusually strong or rapid heartbeat)
___ Other

Surgery (dates):_____

Medications:_____

Family History

Have any of your first-degree relatives (parent, sibling, or child) experienced the following conditions? (Check if yes.)
In addiction, please identify at what age the condition occurred.

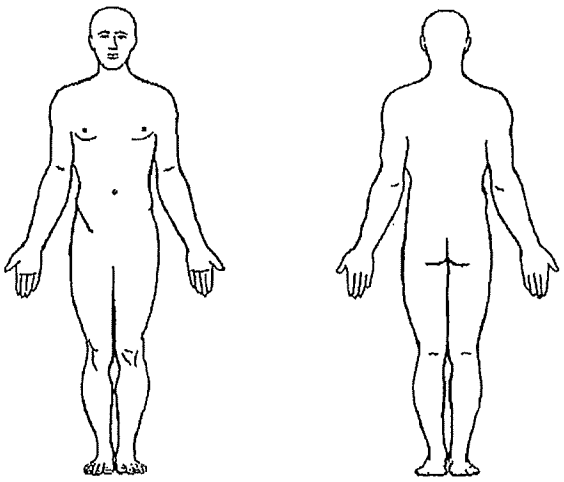
___ Heart arrhythmia
___ Heart attack
___ Heart operation
___ Congenital heart disease
___ Premature death before age 50
___ Significant disability secondary to a heart condition
___ Marfan syndrome
___ High blood pressure
___ Cancer
___ Diabetes
___ Other major illness_____

Pain/Injury Location

Pain rating currently: /10
Worst pain: /10
Best pain: /10

Describe the pain feeling: (ex. Sharp shooting, pins and needles, dull ache, etc.) _____
_____
_____

Mark areas of pain:



Signature:_____ Date:_____

The above information is accurate and true to the best of my knowledge, and I give my consent for the evaluation and any subsequent treatment to be performed.

Rehab Specialists OF IDAHO
Occupational, Physical & Speech Therapy
Professional Plaza Suite 110
Rexburg, Idaho 83440
208-359-9570
208-359-9580 Fax

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. The privacy of your medical information is important to us.

We are required by federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. This notice takes effect September 1, 2007 and we will follow the privacy practices that are described in this notice while it is in effect.

Uses and Disclosures of Protected Health Information

We will use and disclose your protected health information about your treatment, payment and health care operations.

For Treatment – We may use or disclose medical information about you to facilitate medical treatment or services by providers, doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you to ensure necessary information to diagnose or treat you.

For Payment – We may use and disclose your medical information to determine eligibility for benefits, facilitate payment for the services you receive from health care providers, and to determine benefit responsibility or coordinate coverage. For example, this would be submitting your bill to your insurance company for reimbursement.

Healthcare Operations – We may use or disclose, as needed, your medical information in order to conduct certain business and operational activities, normal office procedures, such as quality control, case management and coordination of care. For example, we may use a sign-in sheet at the registration desk or call out your name in the waiting room to take you to an assigned room for treatment. We may also share your health information with third party "business associates" such as billing or transcription services.

Uses and disclosures based on your written authorization – Other uses and disclosures of your health information will be made only with your authorization, unless otherwise permitted or required by law. An example of this would be when the law requires that we report information to government agencies and law enforcement personnel. If you give us written authorization, you may revoke it in writing at any time.

Your revocation will not affect any use or disclosures permitted by your authorization, we will not disclose your health information except as described in this notice.

Others involved in your health care – Unless you object, we may disclose to a member of your family, close friend or any other person you identify that directly relates to involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Marketing – We may use your health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your health information to a business associate to assist us in these activities.

Research – We may use or disclose your health information for research purposes in limited circumstances.

Public Health and Safety - We may disclose your health information to the extent necessary to avert a serious and imminent threat to your health and safety or health and safety to others. We may disclose your health information to government agencies authorized to oversee health care systems, programs, and to public health authorities for public health purposes.

Health Oversight – We may disclose your information to a health oversight agency for activities authorized by law, such as audits, investigation and inspection. Oversight agencies include benefit programs, regulatory programs and civil rights laws.

Lawsuits and Disputes – If you are involved in a lawsuit or dispute, may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

PATIENT RIGHTS

Right to Inspect and Copy – You have the right to look at or get copies of your protected health information, with limited exceptions. You have the right to inspect and copy medical information that may be used to make decisions about you, submitting your request in writing. We may deny your request to inspect or copy in certain very limited circumstances. If you are denied access to medical information, you have the right to request an amendment for as long as the information is kept.

Accounting of Disclosures – You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities after September 1, 2007. We will provide you with the date on which we made the disclosure and the name of the person or entity to which we disclosed your protected health information.

Restriction Requests - You have the right to request (in writing, signed by an authorized person to make such an agreement in our behalf) that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement.

Confidential Communication – You have the right to request that we communicate with you in confidence about your protected health information by alternative means or at an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, and if it continues to permit us to bill and collect payment from you.

Right to Correct, Update, and Amend – You have the right to request that we amend your protected health information. Your request must be in writing, and must explain why the information should be amended.

We may deny your request if we did not create the information you amended or for certain other reasons. If we deny your request, we will do so with a written explanation.

If we accept your request to amend the information we will make reasonable efforts or inform others, including people or entities you name, and to include the changes in any further disclosure of the information.

If you want more information regarding our privacy practices or have questions or concerns, please contact us using the information below:

Rehab Specialists of Idaho
Occupational, Physical & Speech Therapy

Office Manager
36 Professional Plaza Suite 110
Rexburg, Idaho 83440
208-359-9570
208-359-9580 Fax

If you believe we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may comment using the information below:

U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
202-619-0257 or Toll Free 1-877-696-6775

We support your right to protect the privacy of your protected health information.
You will not be penalized for filing a complaint.