

Idaho Physical Medicine and Rehabilitation, PA
REGISTRATION FORM
(Please Print)

Today's date:				Primary Care Provider:					
PATIENT INFORMATION									
Patient's last name:		First:		Middle:		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No		If not, what is your legal name?		(Former name):		Birth date: / /		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino		Preferred Language:		Email address:					
Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> African American <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Other									
Street address:				Social Security #:		Home phone #:		Cell Phone#:	
P.O. Box:		City:		State:		ZIP Code:			
Occupation:		Employer:				Work phone #: ()			
Chose clinic because/Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan		<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work		<input type="checkbox"/> Yellow Pages		<input type="checkbox"/> Other			
Pharmacy		Address/Ph#							

INSURANCE INFORMATION									
(Please give your insurance card to the receptionist.)									
Person responsible for bill:		Birth date: / /		Address (if different):		Home phone #: ()			
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No									
Occupation:	Employer:	Employer address:				Employer phone #: ()			
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No									
Please indicate primary insurance		<input type="checkbox"/> [Insurance]							
Case Manager Name		Phone#		<input type="checkbox"/> Medicaid #		<input type="checkbox"/> Other			
Subscriber's name:		Subscriber's #:		Birth date: / /		Group #:		Policy #:	Co-payment: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse		<input type="checkbox"/> Child	<input type="checkbox"/> Other			
Name of secondary insurance (if applicable):			Subscriber's name:			Group no.:		Policy no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse		<input type="checkbox"/> Child	<input type="checkbox"/> Other			

IN CASE OF EMERGENCY							
Name of local friend or relative:				Relationship to patient:		Home phone #: ()	Alternate phone #: ()
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Idaho PMR or insurance company to release any information required to process my claims.							
_____ <i>Patient/Guardian signature</i>						_____ <i>Date</i>	

IDAHO PHYSICAL MEDICINE AND REHABILITATION, PA

CONSENT AND CONDITIONS OF TREATMENT

CONSENT FOR TREATMENT. I voluntarily consent to care and treatment of the Patient by Idaho Physical Medicine and Rehabilitation, P.A. ("IPM&R") and its affiliated physicians, practitioners, and staff, including but not limited to outpatient medical, surgical, nursing, and therapeutic care; diagnostic, laboratory, and radiological tests and procedures; administration of pharmaceuticals or anesthesia; and such other care as deemed reasonably necessary or advisable by the attending physician, practitioner or staff member. If IPM&R personnel suffer a needle stick or are exposed to blood or body fluids, I consent to the testing of Patient for any blood-borne disease for the protection of IPM&R personnel.

ADVANCE DIRECTIVES (APPLIES ONLY TO PATIENTS RECEIVING TREATMENT IN THE IPMR AMBULATORY SURGERY CENTER (ASC))

Please indicate whether the Patient has executed an advance directive, e.g.:

Living Will Durable Power of Attorney POST Other (describe): _____

I understand that it is IPM&R's Ambulatory Surgery Center policy not to comply with advance directives that would prohibit life sustaining treatment. I consent to such treatment on behalf of the Patient, and agree that any contrary directions in the Patient's advance directives shall be suspended while the patient receives care at IPM&R Ambulatory Surgery Center.

CONDITIONS FOR TREATMENT AT IPM&R. In consideration for the care and treatment that Patient will receive or has received at IPM&R, I agree to the following:

- 1. Patient Responsibilities.** I agree to comply with the Patient Responsibilities set forth in IPM&R's separate Notice of Policies, Patient Rights, and Patient Responsibilities.
- 2. Payment.** I agree that I am responsible for any co-payments, deductibles or other charges for services to Patient that are not paid by insurance, government programs, or other payers, except as prohibited by applicable law or any agreement between my insurance company and IPM&R. I agree to make such payments according to IPM&R's regular terms of payment. Where appropriate, I agree to submit and cooperate with IPM&R in submitting claims to entities from which payment may be obtained, including any government program, insurance company, or other third parties. I understand that I will remain responsible for any amount not paid by insurance or a third party. If the Patient's account becomes delinquent, I agree to pay interest and fees according to IPM&R's policies, including but not limited to reasonable costs of collection, collection agency fees, attorneys fees, and court costs. I agree that any overpayments collected for Patient's admission or treatment on this occasion may be applied directly to any delinquent account of Patient.
- 3. Assignment.** I hereby assign and authorize direct payment to IPM&R of any payments or other benefits to which I or the Patient may be entitled from any government program, insurance company, or other entity that is or may be liable for costs associated with Patient's care. I agree that this assignment will not be withdrawn or voided at any time until Patient's account is paid in full.
- 4. Billing Practices.** I understand and agree that any quote of charges for services rendered and/or insurance benefits available are estimates based upon the best information available at the time. IPM&R may amend such quotes and I will be responsible for charges for services actually rendered. I understand and agree that IPM&R will require payment of all accounts at the time the services are rendered unless IPM&R has expressly agreed to contrary arrangements. Where insurance is available, IPM&R will bill and allow a reasonable time for the insurance company to pay. I will be responsible for any amount not covered by insurance. Should payment not be received, the Patient and I will be billed for all charges and interest. Payment is due upon receipt of the bill.

PERSONAL PROPERTY. I understand and agree that IPM&R does not assume any responsibility for my personal property and shall not be liable for any loss or damage to such personal property.

NO GUARANTEE. I understand and agree that the practice of medicine is not an exact science and that no guarantees have been made to me regarding the results of Patient's care or treatment at IPM&R.

PERSONS FOR WHOM IPM&R IS NOT LIABLE. I understand that IPM&R is only responsible for the acts of its employees acting within the scope and course of their duties. I understand that persons who are not employed by IPM&R may be involved in my care or treatment, including but not limited to members of the medical staff of IPM&R's ambulatory surgery center, independent contractors, vendors, or product technicians. I understand that IPM&R is not liable for the acts or omissions of non-employees or IPM&R employees acting outside the course and scope of their duties.

NOTICE OF PRIVACY PRACTICES. I have been made available a copy of IPM&R's Notice of Privacy Practices on this or a prior occasion. Copies are available online at www.idahopmr.com , the front desk, or can be mailed to me at my request. [Please initial]: _____

NOTICE OF PATIENT RIGHTS AND PATIENT RESPONSIBILITIES. I have been made available a copy of IPM&R's Patient Rights, and Patient Responsibilities on this or a prior occasion. Copies are available online at www.idahopmr.com , the front desk, or can be mailed to me at my request. [Please initial]: _____

OWNERSHIP DISCLOSURE, Idaho Physical Medicine and Rehabilitation, PA is owned by:

Robert H. Friedman, MD	Christian G. Gussner, MD	Mark J. Harris, MD
Shane A. Maxwell, DO	Kurt A. Mildenstein, MD	Monte H. Moore MD
Barbara E. Quattrone, MD		

[Please initial]: _____

QUALITY CONTROL AND INFECTION CONTROL, IPMR maintains a monitoring program designed to prevent, control and investigate infections and communicable diseases as set forth by nationally recognized infection control guidelines. We do this by using quality assessment and performance improvement plans.

I have fully read, understand, and agree to this Consent and Conditions of Treatment. I certify that I am either the Patient or the Patient's legally authorized representative, and have authority to execute this Consent and Agreement on behalf of Patient. I have had the opportunity to ask questions concerning this Consent and Conditions of Treatment and have had my questions answered to my satisfaction.

(Signature) Date: _____

If signed by a Personal Representative:

Print name of Personal Representative

State authority of Personal Representative or relationship to patient.



NEW PATIENT QUESTIONNAIRE

Please sign **EACH** page of this form.

DATE: _____

CHIEF COMPLAINT: _____

WHO REFERRED YOU? _____

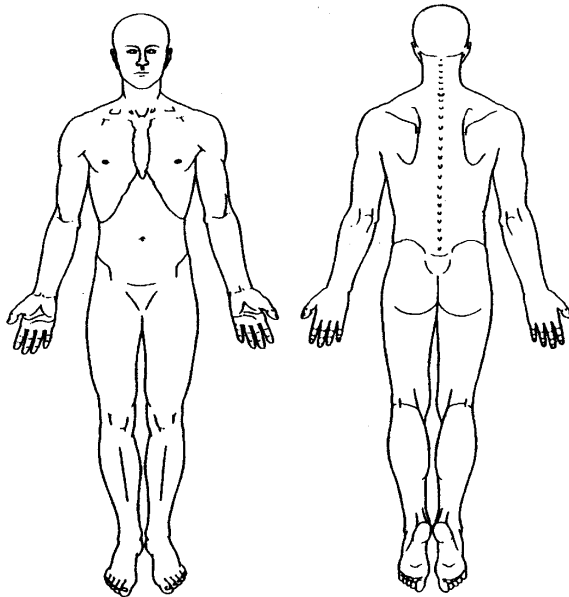
Where is your pain? Please mark on the drawing where you feel pain right now. Use the key below to indicate where and what type of pain.

Pins & Needles = 000

Stabbing = III

Burning =XXX

Deep Aches = ZZZ



RATE YOUR PAIN (Please circle your rating)

0 = No Pain

10 = Extreme Pain

- 1. Right now: 0 1 2 3 4 5 6 7 8 9 10
- 2. At best: 0 1 2 3 4 5 6 7 8 9 10
- 3. At worst: 0 1 2 3 4 5 6 7 8 9 10

4. What makes it better? _____

5. What makes it worse? _____

HAVE YOU HAD ANY OF THE FOLLOWING TESTS OR TREATMENTS FOR THIS PROBLEM?

<u>TESTS:</u>	<u>YES</u>	<u>NO</u>	<u>DATE</u>
X-Rays	_____	_____	_____
MRI	_____	_____	_____
CT Scan	_____	_____	_____
Myelogram	_____	_____	_____
Bone Scan	_____	_____	_____
EMG	_____	_____	_____

<u>TREATMENTS:</u>	<u>YES</u>	<u>NO</u>	<u>DATE</u>
Medication	_____	_____	_____
Injections	_____	_____	_____
Surgery	_____	_____	_____
Physical Therapy	_____	_____	_____

Other Tests or Treatments: _____

PAST MEDICAL HISTORY:

List Medical Problems: _____

List Surgeries & Dates: _____

List Any Medication
Allergies: _____

List Medical Problems that Run in Your Family.

Mother _____ Father _____ Siblings _____

Do you smoke or use tobacco products? (Please Circle) YES NO
If YES, how much/many per day? _____

Do you drink alcohol (beer, wine, etc.)? (Please Circle) YES NO
If YES, frequency/amount per day? _____

Are you or have you in the past used street drugs or been addicted to drugs? YES NO

Please Explain: _____

REVIEW OF SYSTEMS Please choose symptoms you currently are experiencing & write comments as necessary:

- Psychologic** None
 Anxiety, Depression, or PTSD
 Sleep problems
 Anger problems
 Attempted suicide or thoughts
 Homicidal thoughts

- Neurologic** None
 Weakness
 Fatigue
 Loss of bowel or bladder control
 Muscle spasm or stiffness
 Light sensitive
 Memory loss
 Numbness or tingling

- Head/Eyes/Ears/Nose/Throat** None
 Headaches
 Recent or past head injury
 Vision or hearing problems
 Nose bleeds

- Muscles** None
 Muscle pain
 Swelling of the joints
 Muscle weakness
 Muscle spasms or swelling

- Blood/Fluid** None
 Abnormal bleeding
 Anemia
 Generalized swelling
 History of blood clots

- Gastro-intestinal** None
 Constipation
 Diarrhea
 Nausea
 Stomach bleeding
 Rectal bleeding
 Stomach pain
 Loss of bowel control

- GYN/Urologic** None
 Post menopausal
 Early menopause (< age 45)
 History of STD(s)
 Vaginal/Penile discharge
 Painful intercourse
 Pain in genitalia

- Renal** None
 Problems urinating
 Bloody urine
 Difficulty controlling urination
 Pain with urination
 Kidney problems

- Loss of sensation
 Loss of muscle strength
 Balance problems
 Sound sensitive
 Difficulty standing/walking
 Difficulty talking

- Ringing in the ears
 Dizziness
 Blindness
 Difficulty swallowing

- Allergic/Immunologic** None
 History of hepatitis
 Chronic Active Hepatitis
 Anaphylactic/severe allergic reaction
 Frequent infections or fevers

- Pulmonary** None
 Chronic cough or lung infections
 Shortness of breath
 Wheezing
 Sleep Apnea/CPAP/Home oxygen

- Cardiovascular** None
 Chest pain
 Swelling of hands or feet
 Irregular heart beats
 Hot or cold extremities
 Tired with exertion
 Skin changes
 Poor circulation

- Skin** None
 Shingles history
 Skin rash or itching
 Changes in skin color or moles
 Easy bruising
 Skin sensitivity
 Changes to touch

Patient Signature: _____ Date: _____

Reviewed by Provider: _____ Date: _____

MEDICATION LIST

ACROSS THE UNITED STATES, APPROXIMATELY 2.3 MILLION PEOPLE BECOME ILL OR HAVE ADVERSE SIDE EFFECTS FROM MEDICAL THERAPY EACH YEAR. ALSO, ADVERSE DRUG EVENTS ACCOUNT FOR ABOUT 4.7% OF US HOSPITAL ADMISSIONS AND CONTRIBUTE TO AN ESTIMATED \$3.8 MILLION IN COSTS PER HOSPITAL EACH YEAR.

HERE AT IDAHO PHYSICAL MEDICINE AND REHABILITATION CLINICS AND AMBULATORY SURGERY CENTER, WE TAKE MEDICATION DELIVERY VERY SERIOUSLY. WE BELIEVE THAT YOU, THE PATIENT, ARE A KEY MEMBER OF THE TEAM THAT NEEDS TO BE INVOLVED IN ENHANCING ACCURATE AND COMPLETE LIST OF YOUR CURRENT MEDICATIONS. THIS WOULD INCLUDE THE NAME, DOSE, AND FREQUENCY OF EACH MEDICATION YOU TAKE. SINCE THIS INFORMATION IS DETAILED AND MAY BE DIFFICULT TO REMEMBER, WE ASK YOU TO BRING ALL CURRENT MEDICATION BOTTLES (INCLUDING MULTI-VITAMINS, HERBALS, SPECIAL CREAMS OR LOTIONS, LAXATIVES, AND ANY OTHER OVER-THE-COUNTER REMEDIES YOU TAKE) WITH YOU WHEN YOU COME FOR YOUR APPOINTMENT OR PROCEDURE. IF YOU ARE UNABLE TO BRING IN THE BOTTLES, PLEASE BRING IN AN UPDATED MEDICATION LIST INCLUDING ALL OF THE ABOVE INFORMATION. YOU ARE WELCOME TO USE THE TEMPLATE ON THE BACK OF THIS LETTER FOR THIS PURPOSE.

WHEN YOU ARRIVE AT THE CLINIC OR ASC, YOU WILL BE ASKED TO REVIEW THE INFORMATION WE HAVE REGARDING YOUR MEDICATION IN OUR MEDICAL RECORD AND TO EDIT IT BASED ON YOUR MEDICATION BOTTLES OR THE MEDICATION LIST THAT YOU BRING IN.

WHEN YOU LEAVE OUR FACILITY, WE WILL GIVE YOU AN UPDATED LIST OF YOUR MEDICATIONS FOR YOU TO TAKE TO YOUR NEXT PROVIDER OF CARE.

WE ARE DEDICATED TO PROVIDING THE HIGHEST QUALITY, SAFEST CARE POSSIBLE, AND WE APPRECIATE YOUR PARTNERSHIP TO SUPPORT US IN ACHIEVING THIS GOAL. PLEASE FEEL FREE TO CONTACT US AT (208) 884-1333 OR 489-4016.

SINCERELY,

The Providers at IPMR



IPMR Financial Policy

INSURED

We participate in most major health plans. We have contracts with many HMO's, PPO's, insurance companies and government agencies including Medicare and Medicaid. Our business office will submit claims for any services rendered to a patient who is a member of one of these plans and will assist you in any way we reasonably can to help get your claims paid. It is the patient's responsibility to provide all necessary information before leaving the office. If you have a secondary insurance we will automatically file a claim with them as soon as the primary carrier has paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.

You must present your insurance card at the time of your appointment.

If you are insured by a plan we do business with but don't have an insurance card with you, payment in full for each visit is required until we can verify your coverage.

If you are a member of an insurance plan with which we do not participate, payment in full is due at the time of service

Non-Covered And Out Of Network Services:

Medical services that are considered by your insurance company to be non-covered, out of network, or not medically necessary will be your responsibility.

UNINSURED

If you do not have group or individual medical insurance, payment for all professional services is expected at the time of their visit. You will be eligible for a prompt pay discount as outlined in the IPMR Prompt Pay discount policy.

MOTOR VEHICLE ACCIDENTS (MVA)

IPMR will verify med pay on first party MVA claims and if available submit claims on your behalf until the first party claim exhausts. We do not do any third party billing, and all claims are considered to be your responsibility for payment in full. However, at your request, we will submit a claim to your primary health insurance carrier. You may receive an accident questionnaire from the insurance company to be completed and returned. If the questionnaire is not returned to your medical insurance company and/or we receive a denial on your claim, you will be responsible for payment in full.

WORKMAN'S COMPENSATION

It is your responsibility to provide our office staff with employer name, claim number, case worker and prior authorization if required. If the claim is denied by the workers' compensation insurance carrier, it then becomes your responsibility. At your request, we will submit the claim to your primary medical insurance carrier with a copy of the workers' compensation insurance denial. If your primary medical insurance carrier's claim is denied, you will be responsible for payment in full. Please note, we do not accept out of state workers compensation.

NONPAYMENT

All patient responsible balances that remain delinquent after 90 days, with no response to our requests for payment, may be referred to a collection agency. Please be aware that if a balance remains unpaid, you and/or your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you for emergent issues only.