Idaho Physical Medicine and Rehabilitation, PA
REGISTRATION FORM

Today's date:	Primary Care Provider:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino	Preferred Language:	Email address:

Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Native Hawaiian ❑ African American ❑ White ❑ Hispanic ❑ 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):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ 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? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone #: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ [Insurance]		❑ Medicaid #		❑ Other

❑ ***Is injury from a motor vehicle accident?***	❑ Yes ❑ No		❑ ***Injury WORK COMP related?***	❑ Yes ❑ No

Subscriber's name:	Subscriber's #:	Birth date: / /	Group #:	Policy #:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ 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.

Patient/Guardian signature *Date*

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	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.

_____ Date: _____
(Signature)

If signed by a Personal Representative:

_____
Print name of Personal Representative

_____
State authority of Personal Representative or relationship to patient.

PAIN PATIENT INFORMATION / HISTORY FORM

Name: _____
(First) (MI) (Last)

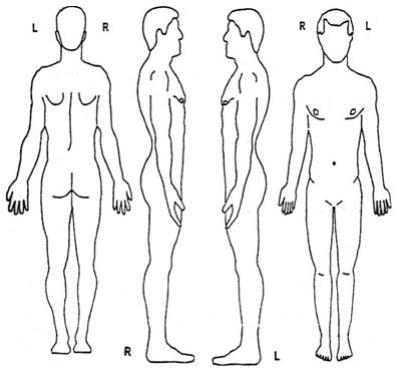
Age:_____ Sex: Male ☐ Female ☐ Weight: _____ Height: _____ Right/Left Handed _____

Referring Physician: _____ Primary Care Physician: _____

Please briefly describe your main problem: _____

_____

Indicate on the pictures below the area(s) of your pain. Use "X" for pain and "0" for numbness.



When did your pain start? (approximate date) _____
How did your pain start? _____
Is your pain: constant ☐ or comes and goes ☐

RATE YOUR PAIN *(Please circle your rating)*
0 = No Pain ***10 = Extreme Pain***

Right now: 0 1 2 3 4 5 6 7 8 9 10

At best: 0 1 2 3 4 5 6 7 8 9 10

At worst: 0 1 2 3 4 5 6 7 8 9 10

What makes your pain better? _____

What makes your pain worse? _____

What words best describe your pain: (Circle as many as apply)

Sharp Burning Throbbing Shooting Aching Cramping Dull
Crushing Stabbing Tingling Coldness Hotness Electricity
Other _____

What brings on the pain or makes it worse? (Circle as many as apply)

Sitting Standing Walking Twisting Lifting Sneezing
Coughing Using Arms Bending forward Bending backward
Other _____

What eliminates or eases the pain? (Circle as many as apply)

Lying down Standing Exercise Arthritis Medicine Pain Pills
Muscle Relaxants Nothing Other _____

Do you have loss of control of your bowels or bladder? Yes:☐ No:☐
Do you have pain that shoots down your arms or legs? Yes:☐ No:☐
Do you have any increasing weakness in your arms or legs? Yes:☐ No:☐

Please any of the following medical problems you have had (circle as many as apply)

Heart Problems	Asthma	Lung Problems	Metal in eye(s)
Heart Attack	Kidney Failure	Depression	Claustrophobia
High Blood Pressure	Kidney Infections	Headaches	
Stroke	Liver Problems	Glaucoma	
Blood Clots	Thyroid Problems	Seizures	
Diabetes	COPD	Ulcers	
Hepatitis	Pacemaker	Immune Disorder	

Cancer (type) _____ Other _____

Please list all past surgeries you have had:

Year: ____: _____. Year: ____: _____. Year: ____: _____.
Year: ____: _____. Year: ____: _____. Year: ____: _____.
Year: ____: _____. Year: ____: _____. Year: ____: _____.

Please list all current prescription medications and any other medications:

Medication	Dose and Frequency

Do you take any of the following medicines: (Circle any that apply)

Coumadin Aspirin Plavix Lovenox Heparin

Do you have any **MEDICATION ALLERGIES?** Yes:☐ No:☐
If yes, list drug and reaction: _____
_____

TESTS:

X-Ray:_____

MRI:_____

CT Scan: _____

Bone Scan: _____

EMG: _____

WORK HISTORY:

What is/was your occupation? _____

☐ Work fulltime ☐ Work part time ☐ Unemployed ☐ Homemaker

☐ Retired ☐ On Disability ☐ Other: _____

When did you last work? _____

If your pain is work related, what is the date of your injury? _____

Do you currently have an attorney in regards to your pain condition? ☐ Yes ☐ No. If yes, please provide name and phone number: _____

SOCIAL HISTORY:

Are you: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Do you have children? ☐ Yes. ☐ No. How many? _____
Who lives in your home with you? _____
Do you smoke? ☐ Yes. ☐ No. If yes, how many packs of cigarettes per day? _____
Are you a former smoker? If yes, when did you quit? _____.
Do you drink alcohol? If yes, how much in a week? _____.
Do you have a history of alcohol, street drugs, or prescription medicine abuse? ☐ Yes ☐ No.
Have you ever been arrested or convicted on a drug or alcohol related charge? Yes ☐ No ☐ If yes, please explain and provide dates. _____
_____
_____

SLEEP AND MOOD:

How many hours a night do you sleep? _____
Have you ever been diagnosed with depression, psychosis, schizophrenia, or bipolar disorder?
☐ Yes ☐ No If yes, which one(s)? _____
Are you seeing a psychiatrist or psychologist? ☐ Yes ☐ No For what? _____
_____
Do you have any thoughts of hurting yourself or others? ☐ Yes ☐ No If yes, please explain: _____
_____
Do you have family history of any of these problems? (Circle as many as apply) Alcoholism
Depression Substance Abuse Mental illness
Cancer Stroke Heart Problems Other_____

Please provide us with any additional information that you feel would assist us in treating your pain: _____
_____
_____

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

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

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

Neurologic O None
- *O Weakness*
- *O Fatigue*
- *O Loss of bowel or bladder control*
- *O Muscle spasm or stiffness*
- *O Light sensitive*
- *O Memory loss*
- *O Numbness or tingling*
- *O Loss of sensation*
- *O Loss of muscle strength*
- *O Balance problems*
- *O Sound sensitive*
- *O Difficulty standing/walking*
- *O Difficulty talking*

Head/Eyes/Ears/Nose/Throat O None
- *O Headaches*
- *O Recent or past head injury*
- *O Vision or hearing problems*
- *O Nose bleeds*
- *O Ringing in the ears*
- *O Dizziness*
- *O Blindness*
- *O Difficulty swallowing*

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

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

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

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

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

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

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

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

IDAHO PHYSICAL MEDICINE AND REHABILITATION **PRIOR PAIN MEDICATIONS**

PRIOR MEDICATIONS TRIED				
X	***Generic (Brand Name)***	***HELPED***	***DID NOT HELP***	***ANY SIDE EFFECTS?***
	OVER THE COUNTER			
	Acetaminophen (Tylonel, Excedrin)			
	Ibuprofen (Advil, Midol, Motrin)			
	Naproxen (Aleve, Naprosyn, Anaprox)			
	PRESCRIPTION NSAIDS			
	Celecoxib (Celebrex)			
	Diclofenac (Arthrotec, Cataflam, Voltaren)			
	Diflunisal (Dolobid)			
	Indomethacin (Indocin)			
	Ketorolac (Toradol, Oruvail)			
	Meloxicam (Mobic)			
	TOPICALS			
	Diclofenac (Pennsaid, Voltaren Gel)			
	Lidocaine Patches / Gel			
	MUSCLE RELAXANTS			
	Baclofen (Lioresal, Gablofen)			
	Cyclobenzaprine (Flexeril)			
	Carisprodol (Soma)			
	Diaxepam (Valium)			
	Metaxalone (Skelaxin)			
	Methocarbamol (Robaxin)			
	Orphenadrine (Norflex)			
	Tizanidine (Zanaflex)			
	ANTI-DEPRESSANTS			
	Amitriptyline (Elavil)			
	Duloxetine (Cymbalta)			
	Milnacipran (Savella)			
	Nortyptyline (Pamelor)			
	Venlafaxime (Effexor)			
	ANTI-SEIZURE MEDICATIONS			
	Gabapentin (Neurontin, Gralise)			
	Pregabalin (Lyrica)			
	Topiramate (Topamax)			
	SHORT ACTING OPIATES			
	Codeine (Tylenol #3)			
	Hydrocodone (Norco, Vicodin, Lortab)			
	Hydromorphone (Dilaudid)			
	Morphine Sulfate			
	Oxycodone (Oxy IR, Percocet)			
	Oxymorphone (Opana IR)			
	Tapentadol (Nucynta)			
	Tramadol (Ultram, Ultracet)			
	LONG ACTING OPIATES			
	Buprenorphine Patch (Butrans)			
	Fentanyl Patch (Duragesic)			
	Hydrocodone ER (Zohydro ER)			
	Hydromorphone ER (Exalgo)			
	Methadone Hydrochloride (Dolophine)			
	Morphine sulfate ER (Avinza, Kadian, MS Contin)			
	Oxymorphone ER (Opana)			
	Oxycodone ER (OxyContin, Xtampza)			

IDAHO PHYSICAL MEDICINE AND REHABILITATION **PRIOR TREATMENTS**

PRIOR TREATMENTS TRIED				
X	***TREATMENT***	***HELPED***	***HELPED SOMEWHAT***	***DID NOT HELP***
	Hot Pack			
	Ice			
	Physical Therapy			
	Tens Unit			
	Traction / Inversion			
	Chiropractic			
	Massage			
	Acupuncture			
	Home Exercise Program			
	Yoga / Tai Chi			
	Meditation			
	Counseling			
	Trigger Point Injections			
	Epidural Steroid Injections			
	Facet Injections / RFA			
	Spinal Cord Stimulator			
	SI Joint Injections			
	Other Joint Injections			
	Nerve Blocks			
	Prolotherapy			
	Stem Cell			
	Other:			

Patient Signature: _____ Date: _____

Reviewed by Physician: _____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.