Idaho State University

ISU Physical & Occupational Therapy Associates
1311 East Central Drive, Meridian, ID 83642
Phone: 208.282.2590 / Fax: 833.499.1813

Patient Demographics

Patient Name: _____ **DOB:** _____

Address: _____ **Sex:** ☐ Male ☐ Female

_____ **SS No:** _____

Home/Cell Phone: _____ **Work Phone:** _____

It is ok for us to leave a message regarding your treatment at the following phone numbers? ☐ Home ☐ Cell ☐ Work **Primary Language:** _____

Primary Physician: _____ **Office Phone:** _____

Referred By: _____ **Office Phone:** _____

Insurance Information

Insurance Provider(s): (Please check all that apply)

☐ Blue Cross ☐ Regence BS ☐ Medicare ☐ Medicaid ☐ Pacific Source

☐ Select Health ☐ VA ☐ Ameriben ☐ UHC ☐ Tricare

☐ Private Pay ☐ Student Health ☐ Other: _____

Primary Subscriber ID: _____ **Group No.:** _____

Subscriber Name: _____ **DOB:** _____

Secondary Subscriber ID: _____ **Group No.:** _____

Subscriber Name: _____ **DOB:** _____

Address: (if different from above) _____

Employer: _____ **Student Status:** ☐ FT ☐ PT

Billing Policy

We bill all major insurance companies. We recommend a physician's referral or prescription for services. **Medicare and Medicaid patients are required to have a physician's referral**. All co-pays and estimated co-insurance will be collected at the time of service. If you do not have insurance and have limited financial resources, you may be able to qualify for a discount. If you qualify for a fee reduction, a partial payment may be due at the time of service. At a minimum, payments must be made monthly. Accounts past due more than 90 days will be sent to collections and any cash discounts applied will be removed and you will be responsible for regular therapy pricing.

Consent

I authorize Idaho State University to release information necessary to process insurance claims on my behalf. I understand that I am responsible for all co-pays, co-insurance, deductibles and non-covered charges and understand the billing policy as stated above. I also understand that supervised graduate students may participate in the evaluation and treatment of the patient as part of their educational program, and hold ISU harmless for any incident related to this treatment.

Signed By: _____ **Date:** _____

Parent/Guardian or Responsible Party

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Adult Patient Profile

Patient Name: _____ **DOB:** _____

Person Completing Form: _____ **Age:** _____

Emergency Contact: _____ **Phone No.:** _____

Address: _____ **City & Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Email:** _____

Is it ok for us to leave a message regarding your treatment at the following #s?

Home: ☐ Yes ☐ No **Cell:** ☐ Yes ☐ No **Work:** ☐ Yes ☐ No

Reasons for Rehabilitation

Diagnosis/Conditions/Reasons you are seeking rehabilitation services: _____

_____

_____

Your Primary goal for therapy is to be able to? _____

_____

_____

Things you would like to do at home that you cannot do right now (e.g., talking on the phone, daily activities, hobbies, etc.)

_____

_____

Activities you would like to do in the community that you cannot do right now (e.g., public speaking, going out to eat, ect.)

_____

_____

Health History

Does you have (or have you had) any of the following conditions? Please check all that apply.

Heart Disease	☐ Y ☐ N	Thyroid Disorder	☐ Y ☐ N	Bowel Issues	☐ Y ☐ N
Stroke	☐ Y ☐ N	Kidney Disease	☐ Y ☐ N	Seizures	☐ Y ☐ N
High Blood Pressure	☐ Y ☐ N	Diabetes	☐ Y ☐ N	Bleeding Disorder	☐ Y ☐ N
Lung Disease	☐ Y ☐ N	Arthritis	☐ Y ☐ N	Asthma/Hay Fever	☐ Y ☐ N
Cancer	☐ Y ☐ N	Headaches/Migraines	☐ Y ☐ N	Swallowing Issues	☐ Y ☐ N
Head Injury	☐ Y ☐ N	Concussion	☐ Y ☐ N	Other:_____	☐ Y ☐ N

Are you or could you be pregnant? ☐ Yes ☐ No

How would you describe your general health? ☐ Good ☐ Fair ☐ Poor If fair/poor, please explain:

_____

_____

Have you recently been or have you ever been hospitalized related to the condition for which you are seeking treatment? ☐ Yes ☐ No If yes, please provide the following information:

When: _____ **Where:** _____

How Long (Admit/Discharge Dates): _____

Have you experienced significant weight change (loss or gain) in the past 6 months?

☐ Loss ☐ Gain ☐ No Change If yes, how many pounds? _____

Was the change in weight intentional or expected? ☐ N/A ☐ Yes ☐ No

List any dietary restrictions (diabetic, food allergies, etc.): _____

_____

Are there any other health problems that you would like us to know about? ☐ Yes ☐ No

If yes, please explain: _____

_____

Do you use a wheelchair, walker, or other assistive device for mobility? ☐ Yes ☐ No

If yes, identify which type of device: _____

Do you have any balance problems? ☐ Yes ☐ No

Do you have left or right sided weakness? ☐ Yes ☐ No If yes, which side: _____

Have you had any previous surgeries? ☐ Yes ☐ No If yes, please explain below.

	Surgery/Procedure	Month/Year
1.		
2.		
3.		
4.		

Does you have any allergies? ☐ Yes ☐ No If yes, please list any allergies and the reaction you experience to each below (e.g., allergies to medications, latex, foods, products, etc.)

	Allergen	Reaction
1.		
2.		
3.		
4.		
5.		

Medications:

Are you currently taking any medication? ☐ Yes ☐ No If yes, please list below.

1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Previous Therapies:

Type of Therapy	Dates	Agency	Name of Therapist
Speech Therapy			
Physical Therapy			
Occupational Therapy			
Psychological/Counseling			
Other Rehab			

Special Needs: (Please check all that apply)

Vision: ☐ No Problems ☐ Glasses/Contact Lenses ☐ Visual Difficulties ☐ Glasses for Reading ☐ Require Enlarged Print

Communication: ☐ No Problems ☐ Difficulty Reading ☐ Difficulty Writing

☐ Communication Needs/Devices/Assist, please specify: _____

_____

Hearing: ☐ No Problems ☐ Hearing Aid(s) ☐ Difficulty Hearing

Living Situational/Level of Independence:

Home Type: ☐ Mobile/Trailer ☐ Single Level ☐ Split Level ☐ Multi Story ☐ Apt./Condo/Townhouse

☐ Other: _____ # of Steps to Main Living Space: _____

Live With: ☐ Spouse or Significant Other ☐ Grown Children ☐ Friend(s) ☐ Alone ☐ Caregiver

☐ Assisted Living ☐ Long-Term Care Facility ☐ Other: _____

Independence: Please rate your ability to perform the activities below, using the letters I = Independent A = Assistance

Bathing/Grooming _____ Dressing _____ Household Chores _____ Stairs _____ Driving _____

Education/Work History:

☐ _____ Grade ☐ High School Diploma ☐ Assoc. Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ Post Graduate

I learn best by: ☐ Discussion ☐ Demonstration ☐ Written Language ☐ Videos ☐ Other: _____

Is there any information or education that you would like your therapist to provide to you? ☐ Yes ☐ No

If yes, please explain: _____

Work Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Medical Leave ☐ Retired

Occupation: _____ **Do you have any vocational concerns?** ☐ Yes ☐ No

Psychosocial History:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Children (how many): _____ **Ages:** _____

Is there anything in your home environment that causes concern(s) for your safety or for other family members?

☐ Yes ☐ No If yes, please explain: _____

Do you have any special cultural, religious, or spiritual practices that you would like us to recognize/address while here?

☐ Yes ☐ No If yes, please explain: _____

Are you experiencing any of the following: ☐ Loss of interest in previously enjoyed activities ☐ Feelings of Hopelessness

Below are words to describe your personality and behavior. Circle all that apply and underline all that you had before your accident/stroke/diagnosis.

Happy	Aggressive	Depressed	Enthusiastic	Friendly
Warm	Independent	Energetic	Distractible	Jealous
Tense	Prefers to be Alone	Dependent	Affectionate	Relaxed
Critical	Easily Fatigued/Tired	Directive	Can't Sleep	Impatient
Shy	Vigorous	Calm	Irritated	Angry

List description(s) not listed above: _____

Personal Interests/Activities:

What are your favorite leisure activities/hobbies? _____

What are your favorite TV shows? _____

What magazines/books/newspapers do you read? _____

Do you like to talk on the phone? ☐ Yes ☐ No

Do you use the internet/email? ☐ Yes ☐ No

Is there anything else you would like us to know that would help us to best serve your needs?

_____

_____

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Consent for Participation

I, _____, give permission for the faculty and students of Idaho State University Physical & Occupational Therapy to use information gathered from my participation for educational training and research. I understand that students, under the supervision of the fully licensed faculty, will be observing and working with me as part of their training.

I understand that I can withdraw from my participation at any time during this experience and revoke my permission to use the information pertaining to my case. If I elect to withdraw and revoke my permission, I will inform the faculty member whose signature appears below or the department chairperson of this action in writing. I further understand that a copy of this form will be given to me upon my request, and the original will be kept on file for the period of five (5) years in the Department of Physical and Occupational Therapy.

I am aware that fees for services I received will be collected by the clinic on the day of treatment unless otherwise arranged with the clinic receptionist or clinic director. I further understand that should I need to cancel an appointment, I must provide 24-hr notice to the clinic by calling (208) 282-2590 to avoid being billed a $10.00 fee for not keeping my scheduled appointment.

_____ _____

Print Name of Patient or Personal Representative *Date*

_____

Signature of Patient or Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____

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Consent for Participation in Publicity Endeavors

I authorize that my protected health information in the form of photographs and video clips may be used by ISU Physical & Occupational Therapy Associates for publicity purposes. The photographs and/or video clips may be on the ISU Physical & Occupational Therapy Associates website, at job fairs, recruiting endeavors, and other events to recruit students to, or promote the professions of physical and occupational therapy studies for the Department of Physical & Occupational Therapy at Idaho State University.

The photographs and video clips may be used for the following purposes:

- To recruit professionals into the fields of physical and occupational therapy studies.
- To promote the Department of Physical & Occupational Therapy.
- To inform potential patients of the services offered at the ISU Physical & Occupational Therapy Clinic at Idaho State University.

This authorization will be used by the Department of Physical & Occupational Therapy at Idaho State University for a period not to exceed 10 years from the date of this authorization.

I understand that I have the right to revoke this authorization, in writing, at any time, by sending such written notification to ISU's Privacy Officer:

ISU Privacy Officer: General Counsel
921 S. 8th Avenue, Stop 8410
Pocatello, ID 83209
(208) 282-3022

I understand that the information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Patient or Personal Representative	*Witness Signature*
Print Name of Patient or Personal Representative	*Print Name of Witness*
Date	*Date*
Description of Personal Representative's Authority or Relationship to the Patient	

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Authorization to Obtain Emergency Medical Treatment

I authorize the ISU Physical & Occupational Therapy Associates to obtain emergency medical treatment at any hospital for the individual listed below. I agree to be fully responsible for any costs related to the said treatment, and to hold harmless Idaho State University of any such costs.

_____ _____

Print Name of Patient or Personal Representative *Date*

_____ _____

Signature of Patient or Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent ☐ Guardian ☐ Power of Attorney

☐ Other: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

The privacy of your protected health information is important to us. We have provided you with a copy of our Notice of Privacy Practices. It describes how your health information will be handled in various situations. We ask that you sign this form to acknowledge you received a copy of our Notice of Privacy Practices.

I acknowledge that I have received a copy of the ISU Physical & Occupational Therapy Associates Notice of Privacy Practices.

_____ _____
Print Name of Patient or Personal Representative *Date*

_____
Signature of Patient or Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

For Office Use Only

We have made a good faith effort in attempting to obtain written acknowledgement of receipt of the Notice of Privacy Practices.

1. Does the patient have a copy of the Notice of Private Practices? ☐ Yes ☐ No
2. If you answered "No" above, please explain why the patient did not sign acknowledgment form:

   ☐ Patient/individual refused to sign _____ (Date of Refusal).
   ☐ Communication barriers prohibited obtaining an acknowledgement.
   ☐ Legal representative not available.
   ☐ Patient bypassed registration.
   ☐ An emergency situation prevented ISU from obtaining an acknowledgement.
   ☐ Other: _____
   _____

Completed By: _____ _____
Signature Date