UNIVERSITY OF MONTANA
PHYSICAL THERAPY CLINIC

32 CAMPUS DRIVE, SKAGGS 129 . MISSOULA, MT 59812 • P 406-243-4006 • F 406-243-4303

Date: _____

First Name: _____ MI: ____ Last: _____ Nickname: _____

Street Address: _____ Apt. or Suite Number: _____

City: _____ State: _____ Zip Code: _____

Phone (with area code): Home/Cell: _____ Email: _____

Social Security Number: ____-_____-_____ Student ID if applicable: 790-_____

Date of Birth: _____ Age: _____
MM/DD/YYYY

Gender: Male ☐ Female ☐ Other/Non-conforming ☐

Referring Physician or N/A: _____

Caregiver/Aide or N/A: _____ Phone #: _____

Emergency Contact

Name: _____ Relationship: _____

Contact Phone: Home/Cell: _____

How did you hear about UM Physical Therapy Clinic? (Circle all that apply, fill in name as indicated please)

Physician (name): _____ Physical Therapist (name): _____

Other Health Care Provider (name): _____ Previous or Current Patient:

Friend: ☐ Family: ☐ Facebook: ☐ Website: ☐ Kaimin: ☐ Other: _____

UNIVERSITY OF MONTANA
PHYSICAL THERAPY CLINIC

Privacy Notice for Patients: Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Do research
- Comply with the las
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- Please contact our Director, Susan Ostertag, at 406/243-2517 if you feel that your rights were violated.
- You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Helping with product recalls
- Reporting suspected abuse, neglect, or domestic violence

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- A physical therapist is required by law to disclose your health information to the appropriate authorities if any of the following are discovered during treatment:
    - Known or suspected victim of abuse, domestic violence, neglect or possible victim of another crime
    - Intent to harm self or any condition that may be of serious threat to health or safety
    - Intent to harm another individual (suspected physical or sexual abuse or neglect)
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.

- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other information

- For more information or to report any concerns contact:
  - Steve Ferdig; 406-243-2417 or Steve.ferdig@umontana.edu
- Please note that we never market or sell personal information
- Effective September 23, 2013

UNIVERSITY OF MONTANA
PHYSICAL THERAPY CLINIC

A hybrid entity of the University of Montana as defined by the HIPAA

PATIENT ACKNOWLEDGEMENT OF RECEIVING NOTICE OF PRIVACY PRACTICE

I, _____(patient's printed name) hereby acknowledge that I was offered a printed copy of the *Notice of Patient Privacy Practices* and consent to the provisions of this Privacy Notice.

Signature: _____ Date: _____

I authorize release of protected health information as defined by HIPAA and allow for electronic/verbal/written communication without my physical presence between the UMPT Clinic and the following parties/individuals:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Signature: _____ Date: _____

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PHYSICAL THERAPY CLINIC

Informed Consent for Physical Therapy

I acknowledge that I have been informed that physical therapy and gym programs involve participation in activities that facilitate gains in flexibility, strength, balance, agility, and endurance through exercise, manual therapy and modalities, which carries a risk, albeit small, of exacerbation of symptoms, or injury.

I understand and agree to the following:

1. My participation in physical therapy, New Directions Gym, and training is strictly voluntary.
2. My participation in each and every exercise and activity within the physical therapy and/ or gym training program is voluntary and I may choose not to participate, or limit my participation, in any exercise or activity at any time.
3. I will pace myself to maintain a level of participation that is safe and comfortable for me.
4. I will advise my physical therapist/student intern/gym staff of any changes in my physical or mental health prior to participation in each session.
5. My physical therapist/student intern/gym staff is available to answer any questions or concerns that I might have regarding my participation, activities, or safety.
6. I will seek further direction or explanation of anything that I do not fully understand, or that causes me concern.

I have read this Informed Consent. I acknowledge that I am signing this document of my own free will, with full knowledge of the risks being assumed.

Signature: _____ Date: _____

Legal Guardians if applicable (Print): _____

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Payment Policies

The University of Montana Physical Therapy Clinic strives to provide high quality, patient-centered physical therapy care while serving as a teaching facility for graduate students. Your care will be provided by a highly qualified physical therapist and graduate physical therapy interns. Please read the following information and initial/sign as requested.

CLINIC POLICIES: Initials required after each paragraph indicating you agree to the following policies:

1. A parking pass will be provided for you when being treated at UMPT Clinic on UM campus. Please note that the pass is applicable only during the time of your physical therapy appointment and using the clinic's parking at other times risks ticketing or towing.
   Initial: _____ **UMPT Clinic Initial:** _____
2. We will bill insurance as a courtesy to you. It is your responsibility to determine if your insurance is accepted, and what is required for us to bill your insurance. If your insurance requires preauthorization, it is your responsibility to inform us that it is required. We will submit forms needed.
   Initial: _____ **UMPT Clinic Initial:** _____
3. It is your responsibility to know your insurance coverage including the deductible, copays, insurance coverage caps and to convey that information to your treating therapist to help with planning of care. Copays will be collected at time of service. It is unlawful to waive deductibles, copayments, coinsurance or other patient responsibility payments. If payment(s) are mistakenly or purposely sent directly to you, or if payment is declined by your insurance company, you understand and agree that you are financially responsible for the charges.
   Initial: _____ **UMPT Clinic Initial:** _____
4. If your account is turned over to a collection agency you will be responsible for:
   - Any and all third party fees including attorney fees and reasonable agency fees.
   - Collection fees in the amount of up to 50% of my total account balance will be added to my remaining balance.

   Initial: _____ **UMPT Clinic Initial:** _____
5. **Please check the box which applies to your specific insurance or method of payment:**
   - ☐ MUS Student Insurance: Copays are required
   - ☐ Out of State Private Insurance: What is it? _____ PreAuth Needed? Yes ☐ No ☐
   - ☐ Private Insurance (In State): What is it? _____ PreAuth Needed? Yes ☐ No ☐
   - ☐ Medicaid: MD referral and Passport Approval is required.
   - ☐ Medicare: Traditional (Medicare pays a maximum of 80%)
   - ☐ Federal, such as TriCare, VA and others may have pre-authorization requirements
   - ☐ Still have a deductible to meet and do not wish to have insurance billed; will pay cash rate at time of service
   - ☐ Payment at time of service: Cash, Credit Card, Check accepted.
   - ☐ Secondary Insurance (Name): _____

   Initial: _____ **UMPT Clinic Initial:** _____
6. If you are unable to keep your appointment please provide 24 hour advanced notice, otherwise a $25.00 cancellation fee will be administered (which is not covered by insurance).
   Initial: _____ **UMPT Clinic Initial:** _____

*I hereby authorize the University of Montana Physical Therapy Clinic to release all information regarding my physical therapy treatment to my health insurance, physician, attorney, or responsible insurance carrier.

*I authorize treatment and agree to be responsible for all payment not covered by my insurance, unless prior arrangements are made.

Signature: _____ Date: _____

Guardian if applicable (Print name): _____

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Billing Policies & Procedures

Billing statements will be sent to UMPT Clinic clients on a monthly basis once an account balance is present. Billing statements will be sent via email as long as an email is provided by a client completing intake paperwork. If an email is not provided by the client, statements will be sent via USPS.

In the event that two months of patient statements have been sent out without any client response or attempt of payment being made, notification of the account being forwarded to UM Business Services for collections will be included with a patient statement sent via USPS billed in the third month. A list of clients receiving notification of pending account transfer to UM Business services will be provided to Rachel Davies, UMPT Clinic Office Manager, to allow an attempt to contact clients either in person, or via phone to inquire about the lack of response to correspondence regarding billing statements. If no reply or payment toward the outstanding balance is received, the account will be turned over to UM Business Services for further action when billing for the fourth month is sent out. Outstanding account balances of less than $100 will not be forwarded to UM Business Services but will be handled internally by UMPT Clinic for collection.

Past clients with an account actively in collections who contact UMPT clinic to schedule a new course of care will be notified of the status of the account and directed to contact Ruth Williams at UM Business Services. Ruth will discuss the outstanding account balance and require 50% of the balance be paid immediately with the remaining balancing being divided into 6 monthly payments. Once the payment plan has been initiated, Ruth will notify UMPT Clinic, and the client will be contacted to schedule a new course of physical therapy care.

UNIVERSITY OF MONTANA
www.umt.edu

UMPT Clinic Billing Procedures

In September of 2020, UMPT Clinic began sending patient statements via email to those individuals providing an email on the intake paperwork at the initial physical therapy visit. Patient statements are sent out monthly. **TO PREVENT YOUR BILLING STATEMENT NOTIFICATION GOING TO SPAM OR JUNK MAIL YOU SHOULD ADD THIS EMAIL** umptclinic@mso.umt.edu **INTO YOUR CONTACTS LIST.**

The billing software (Therabill) used by UMPT Clinic provides a secure format to send patient statements via email. When downloaded, the patient statement will resemble the statements you are already familiar with. The sender information will appear as follows:

From: U of MT Physical Therapy Clinic <umptclinic@mso.umt.edu>

The body of the email will read as follows:
U of MT Physical Therapy Clinic

Hello Joe Smith,

U of MT Physical Therapy Clinic has sent you a secure file.
This file may contain protected health information. **For security reasons, this file will only be available for the next five days. After that time, access to the file will be revoked.**
You can access the file using the link below. To provide an additional level of security, this is a one-time use link; meaning you'll only be able to view the file once using this link.

Click Here to Download File

Your options for payment (check, credit card by mail or phone) will remain unchanged.
Feel free to contact us with any questions you may have regarding this billing procedure.

Respectfully,

Steve Ferdig, PT, DPT, OCS
Director, UMPT Clinic

UM Physical Therapy Clinic
Skaggs Building 129 | Missoula, Montana 59812-1512
t: 406.243.4006 | f: 406.243.4303 | e: umptclinic@mso.umt.edu | w: health.umt.edu/umpt-clinic/

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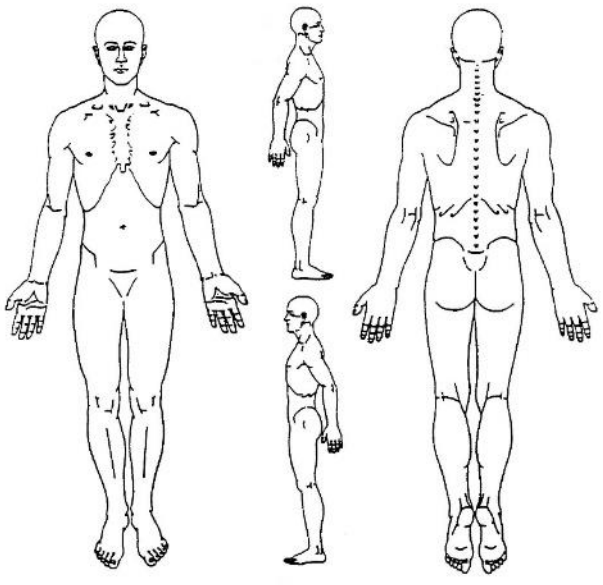
PATIENT QUESTIONNAIRE/HEALTH HISTORY

Name: _____ Date: _____

HISTORY OF PRESENT CONDITION

*Mark or Shade areas of **pain** or **abnormal sensation** on the body chart below*



Please rate the severity of your pain in the past 24 hrs.

-----Mild----- -----Moderate---- --Severe--

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

0 1 2 3 4 5 6 7 8 9 10

1. When did your symptoms begin? _____
2. Was the onset of this episode gradual or sudden?
   ☐ Gradual ☐ Sudden
3. How did your injury occur? _____
   _____
   _____
4. Since onset, are your symptoms getting: (check one)
   ☐Better ☐ Worse ☐ Not Changing
5. Have you had similar symptoms in the past?
   ☐ Yes ☐ No
   If yes, when? _____
6. Describe your pain/symptoms (check all that apply)
   ☐ Aching ☐ Dull ☐ Radiating
   ☐ Burning ☐ Occasional ☐ Sharp
   ☐ Constant ☐ Periodic ☐ Throbbing
   ☐Other _____
7. As the day progresses, do your symptoms:
   ☐ Increase ☐ Decrease ☐ Stay the same
8. Does the pain wake you up at night? ☐ Yes ☐ No
   If yes, is it present: ☐ While lying still
   ☐ Only when changing positions
   ☐ Both
9. Do you have pain/stiffness upon getting out of bed in the morning? ☐ Yes ☐ No
10. What position do you sleep? (check all that apply)
    ☐ Back ☐ Chair/Recline ☐ Stomach
    ☐ Left side ☐ Right Side
    ☐Other _____
11. Since the onset of your current symptoms have you had:
    ☐ Difficulty with control of bowel/bladder function
    ☐ Dizziness or fainting attacks
    ☐ Fever/chills
    ☐ Malaise (vague feeling of bodily discomfort)
    ☐ Night pain/sweats
    ☐ Numbness in the genital or anal area
    ☐ Problems with vision/hearing
    ☐ Unexplained weight change
    ☐ Weakness
    ☐ None of the above
12. What makes your symptoms worse? _____
    _____
13. What makes your symptoms better? _____
    _____
14. Have you had previous treatment for this condition? ☐ Yes ☐ No
    If yes, what kind? _____
15. Have you had any imaging or tests for this condition? ☐ Yes ☐ No
    If yes, what kind? _____

MEDICATION

Please list (or provide a medication list) and **state the purpose of any prescription medications you are currently taking.** Provide the amount you take, how often you take it and if this is oral (by mouth) or otherwise.

_____

_____

_____

Are you taking any of the following over the counter medications?

- ☐ Advil/Motrin/Ibuprofen
- ☐ Antihistamines
- ☐ Aspirin
- ☐ Corticosteroids
- ☐ Tylenol
- ☐ Vitamins/minerals

PRE INJURY FUNCTIONAL LEVEL

Self-care (bathing, toileting, dressing, etc.):

- ☐ Independent
- ☐ Difficulty performing
- ☐ Needs assistance
- ☐ Difficulty performing household chores

Social:

- ☐ Needs assistance with activities outside the home
- ☐ Does not need assistance outside the home

Hobbies: _____

_____

WORK HISTORY

1. Occupation: _____

- ☐ Employed full time
- ☐ Employed part time
- ☐ Homemaker
- ☐ Self-employed
- ☐ Retired
- ☐ Student
- ☐ Unemployed
- ☐ Other _____

2. Are you currently receiving or seeking disability for this condition? ☐ Yes ☐ No

3. If not performing your normal activities at work do you plan to return to your previous activity level? ☐ Yes ☐ No

LIVING SITUATION

- ☐ Live alone
- ☐ Live with family/others
- ☐ Live with caregiver
- ☐ Other _____

Setting:

- ☐ Assisted Living Complex
- ☐ Retirement Complex
- ☐ Group Home
- ☐ Shelter
- ☐ Home/apartment
- ☐ Other _____

GENERAL HEALTH

1. How would you rate your general health?
   ☐ Excellent ☐ Average ☐ Poor
   ☐ Good ☐ Fair

2. Do you exercise outside of normal daily activities?
   ☐ 1-2 days/wk ☐ 3-4 days/wk ☐ 5+ days/wk
   ☐ None ☐ Occasionally
   What kind of exercise? _____

3. Do you drink caffeinated beverages?
   ☐ Yes ☐ No How much per day _____

4. Do you smoke?
   ☐ Yes ☐ No Packs per day _____

5. Do you consume alcohol?
   ☐ Yes ☐ No Drinks per week _____

6. What is your stress level?
   ☐ Low ☐ Medium ☐ High

7. Are you seeing any other health care providers for this current condition? _____

   _____

PAST MEDICAL HISTORY

Have you ever had/been diagnosed with any of the following conditions? (check all that apply)

- ☐ Allergies
- ☐ Arthritis
- ☐ Autoimmune disorder
- ☐ Blood Clots
- ☐ Blood disorders/Anemia
- ☐ Bowel/Bladder issues
- ☐ Broken bones
- ☐ Cancer (type) _____
- ☐ Circulation/vascular
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Epilepsy/Seizures
- ☐ Head Injury (TBI)
- ☐ Heart Problems/Chest Pain
- ☐ High Blood Pressure
- ☐ Kidney problems
- ☐ Liver disorder/Hepatitis
- ☐ Lung problems/Asthma
- ☐ Mental Illness
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Parkinson's disease
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Other _____

FAMILY HISTORY

Has anyone in your **immediate** family ever been treated for any of the following?

- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Osteoporosis
- ☐ Psychological Condition
- ☐ Stroke
- ☐ Other _____