Welcome to _____

Patient Name: **Patient #:** **Date:**

At _____ we believe communication is essential to achieving the best possible patient outcomes. Understanding your needs and expectations is essential to our success. Likewise, it is vital for you to understand the services we offer and our expectations of you.

YOUR FIRST VISIT
Today, you will be introduced to our staff and facilities. The purpose of this initial visit is to evaluate your physical condition, explain the treatment your physician has prescribed, and set progressive rehabilitation goals, also called benchmarks, that will help you enhance your health and physical performance. Your therapist will initiate your treatment, using the technologies and techniques that are appropriate for your condition.

INFORMATION REQUEST
You will be asked to provide us with information about yourself and your medical insurance. As a courtesy, our staff will contact your insurance provider to verify your coverage. Please keep in mind that any and all benefits quoted are not a guarantee of eligibility and/or benefits. If your insurance company requires a co-pay or co-insurance estimate, we will collect this on each date of service.

ABOUT OUR STAFF
Our community-based treatment centers offer a very personalized level of care. A physical therapist or occupational therapist will be responsible for directing all phases of your care. This therapist is a trained, licensed professional who specializes in the treatment of patients with anatomic, neurologic and musculoskeletal disorders. You will also be introduced to support staff that will help to ensure you receive the best possible care and service.

BENCHMARKS (PROGRESSIVE REHABILITATION GOALS)
We establish benchmarks that reflect your physician's expectations and your personal expectations for the results we intend to achieve. With a shared vision for the specific physical gains to be achieved, your therapist will manage your therapeutic care and document the progress you make each visit.

APPOINTMENTS
Your therapist will recommend how often you should schedule appointments and will also discuss home exercises you can do between appointments. It is beneficial to schedule several appointments in advance to ensure the most convenient treatment time and you should always confirm the date of your next appointment at the end of each treatment session. We will make every effort to accommodate your schedule and we will make every effort to stay on schedule so you do not have to wait to be treated. **Please keep your appointment and please be on time**. To achieve your treatment goals, it is important to follow the treatment plan given by your therapist. If you have an emergency or can't come in at your scheduled time, please call us to cancel your appointment and reschedule your next visit.

COMMITMENT TO QUALITY
We strives to achieve the highest standards of excellence. We welcome your feedback about the care and services you receive. If you ever have a question or concern, please speak with your therapist or call our corporate office at 423.238.7217.

PATIENTINFORMATION

Patient Demographics and Insurance

Patient Name: **Patient #:** **Date:**

PERSONAL INFORMATION						
Last	**First**	**MI**	**Suffix**	**Social Security#**	**Date of Birth**	**Sex**
Work Phone	**Primary Phone**		**CellPhone**		**Email Address**	
Mailing Address				**City**	**State**	**Zip**
Employer	**EmergencyContact**		**Patient's Relationship to Contact**		**ContactPhone** Home: Work: Cell:	

GUARANTOR/RESPONSIBLE PARTY INFORMATION			
Guarantor'sName	**Policy ID #**	**Date of Birth**	**HomePhone**
Guarantor'sAddress	**City**	**State**	**Zip**

INSURANCE INFORMATION				
PRIMARYINSURANCE				
Name of Insurance	**Group #**	**PolicyID#**	**Insured'sName**	**Date of Birth**
SECONDARY INSURANCE				
Name of Insurance	**Group #**	**PolicyID#**	**Insured'sName**	**Date of Birth**

DO YOU HAVE MEDICARE? **YES** ☐ **NO** ☐

IF YOU ARE REPRESENTED BY AN ATTORNEY PLEASE IDENTIFY TYPE OF CASE BELOW:

☐ **WORKMANS COMPENSATION**

☐ **AUTO ACCIDENT**

☐ **PERSONAL INJURY (PROPERTY LIABILITY/SLIP & FALL)**

I have reviewed the above information and verify that it is accurate and current.

Signed By Date

Patient: **Patient Number:** **Insurance Co.**

Payment Policy and Estimate of Patient Benefits

Primary Benefits:

☐ Deductible $_____ Amt Met $_____ Amt Remaining $ _____

☐ Co-Pay $_____per visit

☐ Co-Insurance_____% per visit

Patient Responsibility (Due at time of service.)

☐ Pt will be paying $_____to be collected at each visit to be applied toward Copay/Deductible/Co-Insurance.

This amount collected at time of service is determined by combining your Co-Pay, Co-Insurance and any unmet Deductible amounts. As claims process, any balance remaining will be your responsibility.

Insurance Coverage/Limits

Primary: PT_____visits OT_____visits SLP_____visits Dollar Value_____

Secondary Insurance information:_____

This information is not a guarantee of insurance coverage or benefits. This information is provided as a courtesy and was obtained from your insurance company. **Co-insurance amounts are estimates.** You are financially responsible for all charges whether or not paid by insurance and cannot rely on this document as guarantee of insurance coverage or benefits. We encourage you to verify coverage with your insurance company.

I have been counseled regarding my deductible/co-insurance and understand my financial responsibility. I understand that this document is only an estimate of my insurance benefits, is not a guarantee of insurance coverage or benefits, and that I am financially responsible for all charges whether or not paid by insurance. I agree to make payments, towards my financial responsibility, to the clinic during the course of my treatments. I understand that upon the receipt of my first statement, I am responsible to make payments to the Central Business Office for any remaining balance. I also herein agree and understand that I am responsible for any and all costs of collection, should my account become delinquent as defined by _____, including but not limited to late fees, attorney's fees, court costs or fees paid to a collection agency.

_____

Signature of Patient or Guardian

_____ _____

Counseled by Date

Consent to Treat

Patient Name: **Patient #:** **Date:**

The patient authorizes the Physical, Occupational, and/or Speech Therapist to examine and treat the condition as he/she deems appropriate through the use of physical/occupational, and/or speech therapy measures, and the patient gives authorization for these procedures to be performed.

The patient has the right to informed participation in decisions involving his/her health care. This shall be based on clear, concise explanation of his/her condition and of all proposed treatment procedures. All possible risks and/or side effects as well as the probability of success with such procedures shall be disclosed to the patient by his/her attending Physical, Occupational, and/or Speech Therapist. The patient will not hold the Physical, Occupational, and/or Speech Therapist responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

The patient has the right to know who is responsible for authorizing and performing any and all treatment procedures.

The patient shall not be subjected to any procedure without his/her voluntary, competent, and understanding consent or the consent of his/her legally authorized representative. Where medically significant alternatives for care or treatment exist, the patient shall be so informed.

The patient shall be advised if _____ proposes to engage in or perform human experimentation, for the purpose of research, affecting his/her care. The patient has the right to refuse to participate in such research projects.

After reading the above (or having it read to me), I hereby consent to receive physical, occupational, and/or speech therapy at _____, commencing on_____ and terminating when determined by myself, my physician or my Physical, Occupational, and/or Speech Therapist..

I have read (or have had read to me) the above information and understand the content.

_____ _____

Patient (or Guardian Signature Date

Patient: **Patient Number:** **Insurance Co.**:

Assignment of Benefits

I certify that I, and/or my dependent{s) have insurance coverage and have provided _____ with accurate insurance plan information, including a copy of my insurance card, if applicable. I assign directly to _____ my right to payment and/or benefits from any and all sources of payment, including all insurance benefits, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, including deductible, co-pay, co-insurance, ineligible charges and charges for non-covered services.

I authorize the use of my signature on all insurance submissions. _____ may use my health care information and may disclose such information to my insurance company {as named by me in the provision of my insurance card and billing information) and their agents for the purpose of obtaining payment for services and determining insurance benefits for related services. This consent remains in effect until all amounts owed for services provided by my treatment plan are collected.

I hereby designate, authorize and convey to _____, to the fullest extent permissible under law and any applicable insurance policy and/or employee health care benefit plan: {1) the right and ability to act as my Authorized Representative in connection with any claim, right or cause of action that it may have under such insurance policy and/or benefit plan, including but not limited to internal appeals or litigation; and {2) the right and ability to act as my Authorized Representative to pursue such claim, right or cause of action in connection with said insurance policy and/or benefit plan {including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of the Employee Retirement Income Security Act of 1974 {"ERISA"), as provided in 29 CFR § 2560.503-1{b){4), with respect to any health care expense incurred as a result of the services I received from _____ and, to the extent permissible under the law, to claim on my behalf, such benefits, claims or reimbursement and any other applicable remedy, including fines or injunctive relief.

Medicare Patients Only: I hereby certify that the information given by me in applying for payment for Medicare benefits under the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, the Center for Medicare and Medicaid Services, or any of its intermediaries or carriers, any information needed for this or a related Medicare claim. I understand that unless I qualify for the cap exception, Medicare will not pay for therapy services that exceed the Medicare allowable thresholds. If services qualify for the exception process, then standard Medicare deductibles and co-insurances will continue to apply toward mycharges.

Cancellation Policy

We value you as a patient and want you to receive the maximum benefit from our therapy program. We schedule patients and give specific appointment times so that you can conveniently and efficiently make use of your time. We ask that you do the same for us by keeping your appointment schedule. If you must change your appointment, please do so in advance. Our policy is listed below:

- If throughout the course of therapy, you cancel appointments consistentlywithout rescheduling, we may ask you to discontinue therapy and we may contact your physician.
- If throughout the course of therapy, you No Show or No Call consistently, wemay ask you to discontinue therapy and we may contact your physician.
- If you are more than 15 minutes late for your scheduled appointment time, wereserve the right to ask you to reschedule your appointment

_____ _____

Signed By Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: **Patient #:** **Date:**

_____(Initial Here) I acknowledge that I have been offered a copy of the Notice of Privacy Practices.
or
_____(Initial Here) I refuse to acknowledge receipt of the Notice of Privacy Practices. I understand that _____ will not refuse to provide services to me even if I refuse to acknowledge such receipt.

_____ _____
Signature of Patient or Personal Representative Witness

_____ _____
Name of Patient or Personal Representative Date

For Staff Only: If patient or personal representative refused to acknowledge receipt, provide an explanation here:
_____
_____

_____ _____
Signature of Employee Date

Authorization to Share Protected Health Information (PHI)

Patient Name: **Date of Birth:** **Patient Account:**

I authorize _____ to discuss my Protected Health and/or Billing information with my spouse, family member(s) or friend(s) listed below:

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

I authorize _____ to discuss or release billing information only to my Attorney(s) listedbelow:

Attorney Name: _____ Law Firm: _____
Address: _____ Phone: _____

Type of Case: ☐ Workman's Compensation ☐ Auto Accident ☐ Personal Injury
Date of Injury or Accident:___/___/___

Attorney Name: _____ Law Firm: _____
Address: _____ Phone: _____

Type of Case: ☐ Workman's Compensation ☐ Auto Accident ☐ Personal Injury
Date of Injury or Accident:___/___/___

This authorization shall expire no later than three (3) years from date of signature.

I understand that after my health information is disclosed, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law; however, refusal to sign would affect _____ ability to communicate with your attorney. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Compliance Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization.

_____ _____
Signature of Patient or Guardian/Representative Date

_____ _____
Print Name of Patient or Guardian/Representative Date

Patient Name: **Patient #:** **Date:**

Who is your Primary Care Physician (PCP)? _____

Are you? Right-handed Left-handed

Living Environment – Does your home have? Stairs with no railing Stairs and railing Ramps Obstacles: _____

Uneven terrain Elevator Assistive devices (raised commode): _____

With whom do you live? Alone Spouse Children Parents Other

How did you hear about us? _____

Employment / Work (Job/School/Play)

Occupation:_____Working full-time Working Part-time Homemaker / Student Retired Unemployed

Health Habits

Smoking Currently: Yes No Alcohol: Current Past Never

Do you exercise beyond normal, daily activities and chores? Yes No

Medical / Surgical History

Please check if you have ever had (circle all that apply):

The first column is used for outcome measures.

Cancer	Arthritis	Lung Problems
Diabetes	Circulation/Vascular Problems	Kidney Problems
Fibromyalgia	Stroke	Broken Bones/Fractures
Obesity	Thyroid Problems	Skin Diseases
Heart Condition	Parkinson's Disease	Hypoglycemia/Low Blood Sugar
High Blood Pressure	Latex Allergy	Ulcers/Stomach Problems
Multiple Treatment Area	Osteoporosis	Allergies
Surgery for this problem	Depression	Developmental or Growth Problems

Within the <u>past year</u>, have you had any of the following symptoms? (circle all that apply)

Chest pain	Bowel problems	Urinary problems
Headaches	Shortness of breath	Dizziness or
Coordination problems	Weakness in arms or legs	Loss of balance
Difficulty walking	Joint pain or swelling	Pain at night
Difficulty sleeping	Loss of appetite	Fever / chills /
Difficulty swallowing	Weight gain	Weight loss
Hearing problems	Vision problems	Other: _____

Patient Name: **Patient #:** **Date:**

Please list any surgeries and include approximate dates (month/year):

_____ ____/_____/_____

_____ ____/_____/_____

FOR MEN ONLY: Have you been diagnosed with prostate disease? Yes No

FOR WOMEN ONLY: Are you pregnant or think you might be pregnant? Yes No

Have you been diagnosed with other OB/GYN difficulties? Yes No

Have you ever had surgery related to women's health? Yes No

Current Conditions / Chief Complaints

When did the problem(s) begin? (month/day/year)_____/____/_____

What happened? _____

Have you ever had this problem before? Yes No

If yes: How long did the problem(s) last? _____

What did you do for the problem(s)? _____

Did the problem get better? Yes No

How are you taking care of the problem(s) now? _____

What are your goals for physical therapy? _____

Are you seeing any healthcare providers for your current problem(s)? (please list) _____

_____

Other Clinical Tests Performed for this Condition

Angiogram (heart catheter)	Bone scan	CT scan
EKG (electrocardiogram)	Mammogram	MRI
NCV (nerve conduction velocity)	X-rays	Stress test (e.g. tread mill, bicycle)

Other: _____

Patient Name:_____ DOB:_____ DATE: _____

Current Medications List

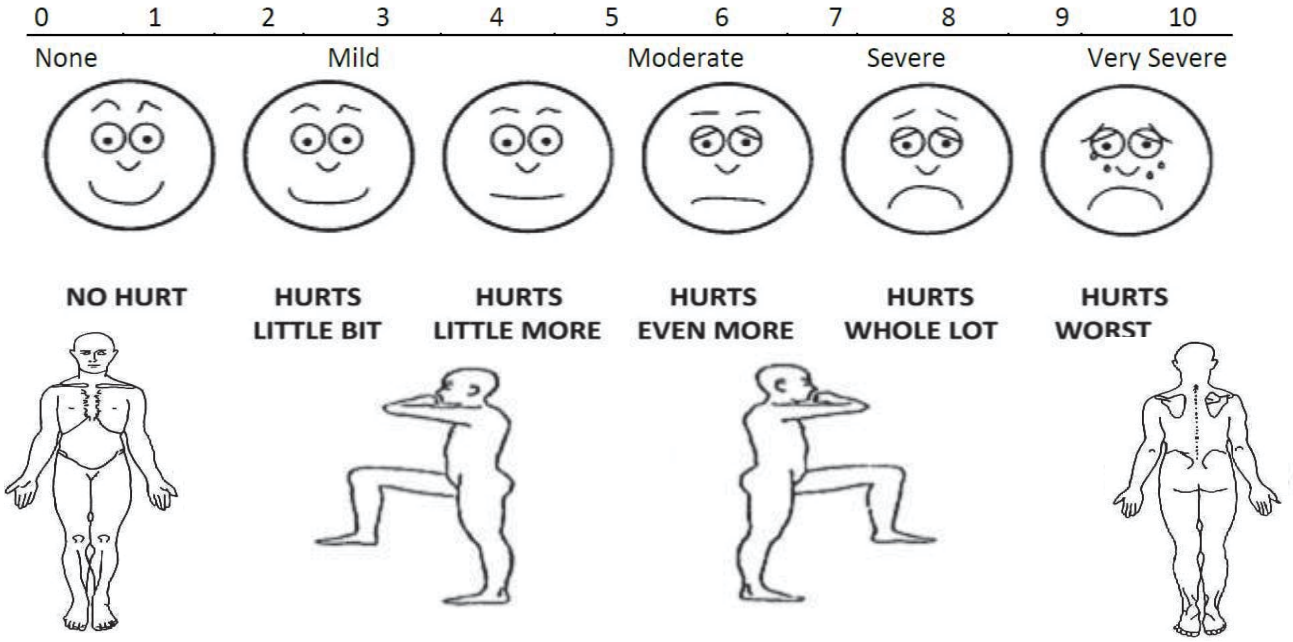
Please include ALL prescriptions, over the counter medications, herbals, and vitamin/mineral/dietary nutritional supplements.

Medication Name	Dosage (25 mg, etc.)	Frequency (3x per day, etc.)	Route of Administration (by mouth, etc.)	Prescribing MD
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				
9)				
10)				

A Continued Medication List page is available for any additional medications

Have you had any falls in the past year? Yes No **If YES, how many?**_____

Pain: Please indicate your level of pain at this time by marking either the numerical or visual scale:



Please mark on the diagram above where you are having your symptoms/pain

To be completed by therapist:

Height:_____

Weight_____