TOTAL REHABILITATION

PATIENT INFORMATION:

Please provide your insurance card(s) for copying and referral from your doctor

Date: _____

Name: _____ Date of Birth: _____
First M Last

Gender: ☐ Male ☐ Female Social Security #: _____

Home Phone: _____ Cell Phone: _____Work Phone: _____

Current Address: _____
Street City State Zip Code

Billing Address (if different than above):_____
Street City State Zip

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Employment Status: ☐ Full Time ☑ Part Time ☐ Light-Duty ☐ Student ☐ Not Employed ☐ Retired

Employer:_____ Position:_____

Address: _____Phone #:_____
Street City State Zip Code

Emergency Contact (and Relationship): _____Phone #: _____

Referring Doctor: _____ Primary Care Physician: _____

Have you been under the care of a Home Health Care Provider? ☐ Yes ☐ No Date of Discharge_____

Name of Home Health Care Provider _____ Phone # _____

*****ATTENTION MEDICARE PATIENTS*** MEDICARE WILL <u>NOT</u> PAY FOR PHYSICAL THERAPY AT TOTAL REHABILITATON IF YOU ARE CURRENTLY RECEIVING <u>ANY TYPE</u> OF SERVICES FROM A HOME HEALTH AGENCY. YOU WILL BE RESPONSIBLE FOR PAYMENT TO TOTAL REHABILITATION FOR SERVICES RENDERED.**

Have you received any physical therapy this year or for **<u>this</u>** injury/ailment? ☐ Yes ☐ No

If yes When?_____ Where?_____ How Long?_____

Recent Hospitalizations? _____ Date Admitted_____ Date Discharged_____

How and where injury/ailment we are treating occurred:_____

Date of injury/onset:_____ Surgery Date for this injury/illness:_____

PATIENT HISTORY:

Name: _____Today's Date: _____
First M Last Gender: ☐ Male ☐ Female
Have you had prior therapy for this injury? ☐**Yes** /☐**No**
If yes, When? _____ For how long - # of days per week_____ # of weeks attended_____

Personal Goals for Therapy
What do you want to achieve from physical therapy? Check all that apply:
☐ Improve home activities ☐ Improve mobility/walking activities ☐ Decrease or eliminate pain/discomfort
☐ Improve leisure/sports activities ☐ Improve self care activities ☐ Return to work

What is your **MAIN**complaint?_____

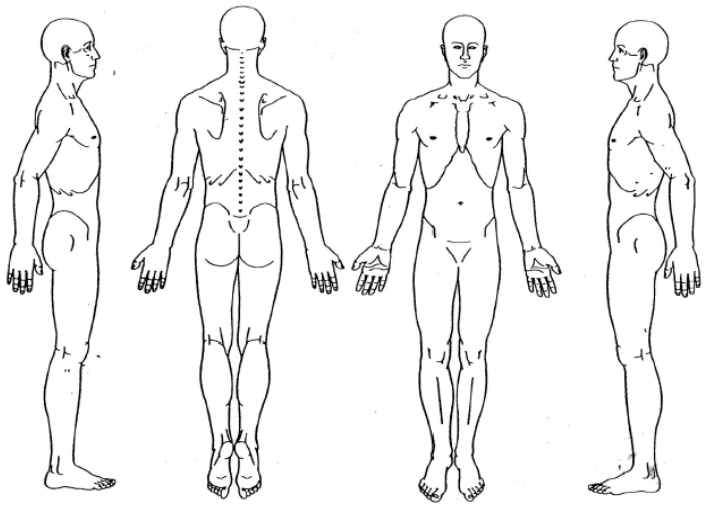
Are you having trouble sleeping ☐**Yes** /☐**No**
Normal hours of sleep _____
Current hours of sleep _____

Please circle your pain level for the following:
What is your pain at rest?
No Pain Worst Pain Imaginable
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

What is your pain with activity?
No Pain Worst Pain Imaginable
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

Activity Level Prior to Injury or Incident
☐ Low ☐ Medium ☐ High
Current Level of Activity
☐ Low ☐ Medium ☐ High

Darken the areas where you are having problems:



Have you ever had or do you currently have any of the following (please circle yes or no):

Heart problems	☐ **yes**	☐ **no**	Have you had a stroke	☐ **yes**	☐ **no**	Cancer	☐ **yes**	☐ **no**
High blood pressure	☐ **yes**	☐ **no**	Poor circulation	☐ **yes**	☐ **no**	Diabetes	☐ **yes**	☐ **no**
Dizziness or Fainting	☐ **yes**	☐ **no**	Metal implants	☐ **yes**	☐ **no**	Pacemaker	☐ **yes**	☐ **no**
Shortness of breath	☐ **yes**	☐ **no**	Neurological disease	☐ **yes**	☐ **no**	Arthritis	☐ **yes**	☐ **no**

Do you currently have any of the following (please circle yes or no):
Uncontrolled leakage of urine? ☐**Yes**☐**No**
Loss of bowel control? ☐**Yes**☐**No**
Is there any chance you might be pregnant? ☐**Yes**☐**no**

Any falls in the past 12 months? ☐Yes☐No

For this injury/ailment have you had an: **MRI** ☐ **yes** ☐ **no** or **X-RAY** ☐ **yes** ☐ **no**
Have you had any recent surgeries? ☐ **Yes** ☐ **no**
If yes please explain and give hospitalization dates:_____

Explain how this injury or onset occurred: _____

Please comment on any other health problems or concerns: _____

_____

Medications: Name _____ Dosage_____ Name _____ Dosage_____

Name _____ Dosage_____ Name _____ Dosage_____

BILLING INFORMATION:

Primary Insurance:

Submit Claims to: _____Policy #: _____ Group #:_____

Name on Policy (if other than patient): _____ Relationship to Patient: _____

Date of Birth of Primary Insured: _____ Social Security No. of Primary Insured: _____

If you listed **Medicare as your Primary Insurance – are you or your spouse actively employed? ☐Yes ☐No

If you listed **Medicaid as your Primary Insurance – Please list your PCP _____

OFFICE USE ONLY

Ins. Verified Date_____ Contact/Adjuster_____ Phone_____

Effective date_____ Annual Deductible_____ Met_____OOP_____ Met_____

Copay_____ %Pay_____ Allowable Visits_____ # Visits Met_____ Pre-Auth: Yes/No_____

Claims mailing address_____

Workers Comp. – Date of Injury_____ Disputes on file: Yes/No _____

Compensable Injury _____ _____

Notes:_____

_____

Secondary Insurance (if applicable):

Submit Claims to: _____ Policy #: _____ Group #:_____

Name on Policy (if other than patient): _____ Relationship to Patient: _____

Date of Birth of Primary Insured: _____ Social Security # of Primary Insured: _____

Responsible Party:

**If you are a minor or someone else will be responsible for your account please list responsible party below:

Person Responsible for Account:_____ Relationship to Patient:_____

Home Phone: _____ Cell Phone: _____Work Phone: _____

Current Address: _____

Street City State Zip Code

ASSIGNMENT OF BENEFITS:

I, _____, hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to Total Rehabilitation. This payment will not exceed my indebtedness to the above mentioned assignee. **This is a direct assignment of my rights and benefits under this policy**. A photocopy of this Assignment shall be considered as effective and valid as the original.

RELEASE OF MEDICAL RECORDS

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, physician or attorney involved in my case. Furthermore, I authorize the release of information pertinent to my case to Total Rehabilitation.

CONSENT FOR TREATMENT

I authorize the staff at Total Rehabilitation to undertake such treatment and procedures as deemed appropriate to improve my condition. It is recognized that the practice of physical therapy is not an exact science and, as such, no guarantees have been made to me about the outcome of treatment. I am advised that I have the full right to a full explanation of any treatment or procedure utilized. I may experience an increase in my current level of pain or discomfort. This discomfort is usually temporary and I will contact my therapist if it does not subside. I understand that I have the right to refuse treatment; but, in doing so, I also understand that the desired outcome of my treatment program may be affected. Persistent refusal to participate or cooperate in the recommended treatment program may result in my discharge from the program.

INSURANCE AND PRIVATE PAY POLICY

Primary and secondary insurances will be billed as a courtesy for patients. Patients may be responsible for their percentage of the charges, co-pays and/or deductibles that their insurance will not cover. Payment arrangements can be made by contacting our billing office.

In the event that my insurance carrier fails to pay according to my current contract, I authorize Total Rehabilitation to initiate a complaint to the Insurance Commissioner on my behalf.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES AND FINANCIAL POLICY

A copy of the Privacy Policy and Practices is posted next to registration window for my information and reading. I understand that a copy of this policy is available at my request.

To the best of my knowledge, the patient information, patient history and billing information is complete and factual. I will report any changes in my insurance coverage to Total Rehabilitation as soon as possible to avoid complications in coverage and timely billing practices. In signing below I understand that I (the patient or responsible party) am ultimately financially responsible for the coverage of my physical therapy charges.

Patient Signature_____ Date_____

Signature of Responsible Party_____ Date_____

Relationship to patient_____ Child's Name_____