HandsOn Rehabilitation

Case History

Name _____ Soc. Sec. # _____ Date _____

Age _____ Date of Birth_____ Sex _____ Marital Status _____

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

E-Mail Address _____

Employer _____ Occupation _____

Emergency Contact: Name _____ Relation _____ Phone # _____

Physician's Name _____ Physician's Phone # _____

Who referred you to our facility? _____

What is your major complaint? _____

How long have you had this condition? _____

What aggravates your condition? _____

Is your condition getting worse? Yes □ No □ Constant □ Comes and Goes □

Is this condition interfering with your: Work □ Sleep □ Daily Routine □ Other_____

Have you sought treatment from other healthcare providers? Yes □ No □

If yes, whom? _____

Length of time under care? _____

Did treatment relieve symptoms? Yes □ No □ Other _____

Did you injure yourself at work? Yes □ No □

Were you involved in an automobile accident? Yes □ No □

If yes, date of injury or accident: _____

Brief description of injury or accident_____

_____

Have you had any other personal injuries or accidents? Yes □ No □

If yes, describe _____

_____

Do you have an attorney? Yes □ No □

Name _____

Address _____

_____

Phone #_____

Please provide all insurance information (cards and forms) to the front desk. All forms must be filled out & signed on the first visit. If there is more than one insurance, information must be provided.

PATIENT MEDICAL HISTORY

Name: _____ ID#_____ DOB: _____

To help us better evaluate your condition please complete this form to the best of your knowledge.
If you have any questions, please ask for assistance. Thank you.

1. If you have Medicare, is a Home Health Agency or Visiting Nursing Association currently seeing you? Yes No

2. Have you received any physical or occupational therapy this year? Yes No

3. If yes, where and when was this service provided? _____

4. In your own words, what is the problem that has brought you here for therapy? _____

_____

5. What would you say is the pain rating for your current condition using a scale of 0 – 10?

(0=no pain, 10=worst pain imaginable) _____ Weight _____Height _____

SYMPTOMS: In regards to your current condition:

Do you have any "pins and needles" or numbness in your extremities?	Yes	No
Do you have any weakness in your arms or legs?	Yes	No
Do you have any coordination or balance problems?	Yes	No
Do you have difficulty walking?	Yes	No
Do you experience dizziness or vertigo with a change in position?	Yes	No
Have you experienced headaches as a result of your condition?	Yes	No
Have you had this problem before?	Yes	No

6. Have you seen anyone else for your current problem?
( ) Physician/MD ( ) Chiropractor ( ) Podiatrist ( ) Orthopedic Surgeon ( ) Dentist ( ) Osteopath/DO
( ) Neurologist/Neurosurgeon ( ) Physical Therapist ( ) Other: _____ Date: _____

7. Do you have a past or present medical history of the following? **(Please check any condition you have a history of. Items not checked are understood to be negative.)**

__ Allergies	__ Depression	__ Multiple Sclerosis
__ Anemia	__ Diabetes Shoe Size _____	__ Osteoporosis
__ Anxiety	__ Dizziness/Vertigo	__ Parkinson
__ Arthritis	__ Emphysema/Bronchitis	__ Rheumatoid Arthritis
__ Asthma	__ Fractures	__ Seizures/ Epilepsy
__ Cancer	__ Gallbladder Problems	__ Smoke
__ Cardiac Condition	__ Hepatitis	__ Speech Problems
__ Cardiac Pacemaker	__ High/Low Blood Pressure	__ Strokes
__ Cholesterol	__ Incontinence	__ Thyroid Disease
__ Circulation Problems	__ Kidney Problems	__ Tuberculosis
__ Currently Pregnant	__ Metal Implants	__ Vision Problems
__ Hearing Impairment	Other: _____	

7. Are you allergic to any medications? Yes No

If yes, please list them: _____

8. Are you allergic to Latex? Yes No Any skin allergies? Yes No

9. Fall History: Injury as a result of a fall in the past year? Yes No Two or more falls in the last year? Yes No

10. Surgical History: Body Region: _____

Surgery Type: _____ Date (M/Y): _____

11. Current Medications: Drug(s) Dosage_____

Reason for taking _____

Separate list provided Yes No

12. Are you taking any NONPRESCRIPTION medications? (Check all that apply)

___ Advil/Motrin/Ibuprofen
___ Aleve/Naproxen
___ Aspirin
___ Tylenol/Acetaminophen
___ Antacids
___ Antihistamines
___ Decongestants
___ Vitamin/mineral/herbal supplements
___ Other: _____

13. DIAGNOSTIC TESTS: **Please check test(s) for current problem only**.
( ) X-rays ( ) CT scan ( ) MRI ( ) Bone Scan ( ) EMG ( ) Bone Density
( ) Blood Chemistry ( ) Ultrasound ( ) Other (please specify) _____

There are inherent risks associated with physical therapy treatment because you will be asked to exert effort and perform activities with increasing degrees of difficulty, which could cause an increase in your current level of pain or discomfort or aggravate your existing injury. There is also a possibility that you could experience a new injury, but this risk is small. You will be able to stop a procedure if you feel a significant increase in pain or discomfort. You will never be forced to perform any procedure that you do not wish to perform.

Based on the above information, I agree to cooperate fully and to participate in all physical therapy procedures and comply with the plan of care as it is established. I acknowledge that I have read and understand the authorization for treatment.

_____ _____
Patient/Legal Guardian Signature Date

I have reviewed this form with the patient. _____ _____
Physical Therapist Signature Date

Our financial policy
We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about fees, financial policy or your responsibility.

Regarding insurance
If you have insurance, we will help you receive maximum benefits once your coverage has been confirmed and the scope of benefits is defined. It is your responsibility to provide our office with accurate insurance information. We are accepting most insurance plans, but each plan varies by employer and insured. You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.
I have read the above policy regarding my financial responsibility to ***Hands-On Rehabilitation, LLC***, for providing physical therapy services to me or the named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to ***Hands-On Rehabilitation, LLC***, the full and entire amount of bill incurred by me or the named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature _____ Date _____

Guarantor Signature _____ Date _____
(If guarantor is not the patient)

If we are not a participating provider with your insurance plan, or you do not have an insurance, payment is expected in full at the time of service. **All payments are due at the time services are rendered.**

Insurance is a contract between you and your insurance company. We file the claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance carrier, other than to supply treatment information as necessary. If your insurance carrier has not paid a claim within sixty (60) days, you will be notified and then have fifteen (15) days to pay the remaining balance.

Motor Vehicle Insurance (PIP)
I do not have health insurance. I request my claims be submitted to my motor vehicle carrier. I understand I will be responsible for bills incurred by me in the event my PIP benefit exhausts or denies. Initial: _____

All unpaid balances will be charged 1.5% interest per month beginning 90 days from the date the balance becomes your responsibility. Initial: _____

Missed appointments
We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call **24-hours** prior to canceling your appointment. Please help us serve you better by keeping your scheduled appointments. A **fifty-dollar** charge will be implemented for missed appointment.
Initial: _____

Release of Information/ Assignment of Insurance Benefits
I authorize the release of any information concerning my health and health care services including PHI needed for processing of claims for payment to my insurance companies or should I request documentation sent to doctors/facilities in the future. If my insurance company will not assign benefits to Hands-On Rehabilitation, LLC, then I understand that I am responsible for payment of all charges including attorney fees incurred with collection of the amount due, regardless of whether or not I am later reimbursed by my insurance plan.

I clearly understand and agree that all services to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professionally services rendered to me will be immediately due and payable.
I have read and understand the above information, and I agree to the terms described:

Patient Signature **Guardian Signature**

_____ _____

Print Name **Relationship to the Patient** **Date**

_____ _____ _____

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITYS IN THE FUTURE.

_____ _____

Please ***print*** your name Please ***sign*** your name

_____ _____

Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer

Credit/Debit Card Payment Authorization Form

Sign and complete this form to authorize your credit/debit card information to remain securely on file at our office and authorize **Hands-On Rehabilitation, LLC** to make a debit to your credit/debit card listed below.

By signing this form, you give us permission to debit your account for any outstanding balances which are not covered or applied to your responsibility or if your insurance company will send payment directly to you for services provided. This is permission for balances on medical services only and does not provide authorization for any additional unrelated debits or credits to your account.

Please complete the information below:

I _____ authorize Hands-On Rehabilitation, LLC to charge my credit/debit card account indicated below for any outstanding balances which are not covered or applied to my responsibility by my Insurance Company. This payment is for MEDICAL SERVICES ONLY.

Billing address _____ Phone # _____

City, State, Zip _____ E-mail _____

Account Type: ☐ Visa ☐ Amex ☐ MasterCard ☐ Discover

Cardholder Name: _____

Account Number: _____

Expiration Date: _____

SIGNATURE _____ DATE _____

I authorize the above named business to charge credit/debit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the services described above. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company so long as the transaction corresponds with the terms indicated in this form. If you do not agree on how your claims were processed it is your responsibility to dispute it with your insurance company.