PATIENT INFORMATION

Name ____ Social Security # ______-______-______
Last First Middle (Nickname) Required

Address ____
Street Address City State Zip

Date of Birth ______________________ Sex: M / F

Home Phone (_____) __________________ Work Phone (____) ____________________

Email ______________________________ Cell Phone (____) ____________________

Employer ___________________________ Occupation __________________________

Referring Physician __________________ Office Phone (_____) __________________

How did you hear about us? ____

RESPONSIBLE PARTY (if other than patient)

Name ____ Social Security # ______-______-______
Last First Middle Required

Address ____
Street Address City State Zip

Date of Birth ______________________ Sex: M / F

Home Phone (______) ________________ Work Phone (____) ____________________

EMERGENCY CONTACT INFORMATION

Name ____________________________________ Relationship ________________________

Home Phone (______) ________________ Cell Phone (_____) ____________________

BILLING INFORMATION

Insurance Company ______________________ Name of Insured ____________________

Address ____ Phone (______) __________
Street Address City State Zip

Claim # ____________________ Date of Accident ________________ State of Accident __________

Adjuster/ Attorney ____________________________________

Address ____ Phone (______) __________
Street Address City State Zip

Welcome to Rehability

Thank you for choosing Rehability as your physical therapy provider. Our commitment is to help you achieve your physical goals in a professional manner, respecting your time and resources. We will work closely with you, your physician and your other health care providers during this process.

FINANCIAL POLICY

As a service to our patients, Rehability will directly bill your insurance for services rendered, but the ultimate responsibility for payment of these services belongs to the patient. Rehability has a competitive fee schedule that falls within 'usual and customary fees' for most insurance companies. In addition, we are committed to establishing a treatment plan that is manageable for both your time and budget.

- **All payments (deductible, co-insurance, or co-payment) are due at the time of service *unless arrangements are made in advance.***
- **For your convenience Rehability accepts cash, credit cards (Visa and Mastercard), and personal checks.**
- **Please inquire about our cash pay policy, especially if you are un-insured or have a high deductible plan.**
- **Any portion of your treatments that is not covered or is denied by your insurance (including worker's compensation claims) becomes your responsibility and is due within 30 days.**
- **A refund will be issued by Rehability when an overpayment has been identified.**
- **Interest will be assessed at a rate of 1.5% per month (18% APR) for unpaid balances over 30 days old.**
- **A $30.00 fee will be charged for each incident that a check is returned due to insufficient funds.**
- **The cost for all supplies/ products (including orthotics) must be paid at time of delivery. A receipt will be provided for the patient to seek reimbursement from the insurance company.**

CANCELLATION POLICY

Failure to keep your scheduled appointments hinders our ability to provide the best possible care to all our patients. We ask that you show us consideration by calling at least 24 hours prior to your appointment if you are unable to attend. This will allow us the opportunity to offer that appointment time to another patient

- **Failure to give 24 hours notice prior to cancellation may result in a $25 "No Show Appointment Fee".** Please note this fee cannot be billed to your insurance company and will be your direct responsibility.
- **Failure to show for 3 consecutive sessions, we will result in discharge from our care.** If you are an industrial injury patient, your claims manager will be notified about the missed visits, and your claim may be discontinued.

Thank you for allowing us the opportunity to serve you. If you have any questions about the above information or any uncertainty regarding your insurance coverage, please do not hesitate to ask for our assistance.

Patient Consent For Treatment

I have read and fully understand Rehability's Financial and Cancellation Policies. I understand that Rehability may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I do hereby consent to such treatment by the authorized personnel of Rehability as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment except acts of negligence.

Signature of Patient/ Guardian ______________________________ **Date**______________________

Acknowledgement Receipt Of Patient Privacy Practice Notice

I, ______________________________, have received the Notice of Patient Privacy Practices from Rehability.
Print Name

Signature of Patient/ Guardian________________________________ **Date**______________________

REHABILITY
Physical Therapy

Your Health Status

Name: ______________________ **Date of Birth:** __________ **Age:** ______ **Date:** ______

Why do you need physical therapy today? ____

List any previous treatment(s) you have had for this condition: ______________________________

Please check any of the following health conditions that you currently or previously experienced.

- ☐ Heart disease or chest pain
- ☐ Blood pressure issues
- ☐ Breathing problems (asthma, emphysema, etc.)
- ☐ Circulation problems (varicose veins, phlebitis, etc.)
- ☐ Blood disease (anemia, AIDS, etc.)
- ☐ Liver problems (hepatitis, jaundice, etc.)
- ☐ Cancer
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Stroke/ Head injury
- ☐ Headaches
- ☐ Fainting/ Dizzy spells
- ☐ Seizures
- ☐ Hernia
- ☐ Unexplained weight loss
- ☐ Pregnant/ Possibly pregnant
- ☐ Previous surgery____________
- ☐ Other_______________

List all medications you are currently taking. ____

Are you currently engaging in any form of exercise? Yes/No **If yes, list activity and how often.** ________________

____

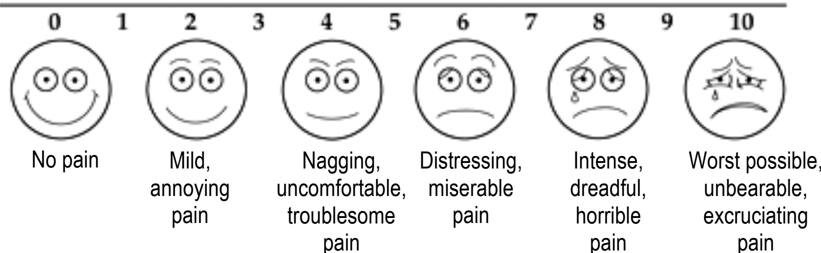
What is your job? ____

Describe the types of activities involved in your job/ normal day (e.g., heavy lifting, stair climbing, walking, sitting at a desk, bending). ____

What do you hope to accomplish with physical therapy? ______________________________________

____

Circle the pain level you are experiencing TODAY



Pain frequency:

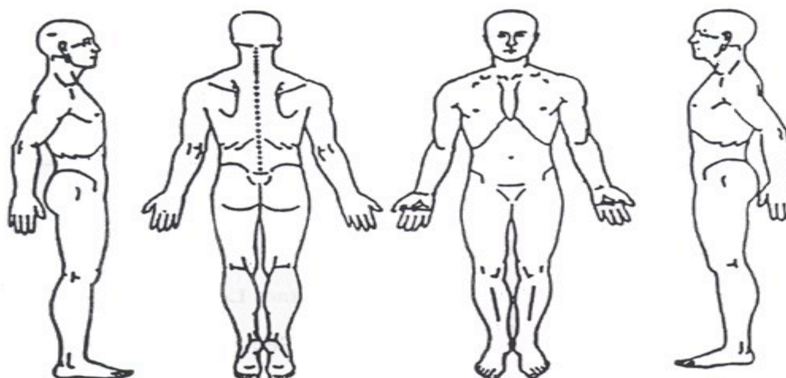
___ Constant
___ Comes and goes at regular times
___ Happens once in a while

Relationship of pain to sleep:

___ Wakes from sleep
___ Prevents sleep
___ Better after sleep

Put X's on the diagram where you are currently feeling pain:

Right Back Front Left



Notice of Patient Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

LEGAL DUTY

Rehability is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Rehability uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, communicating with your other medical providers, and evaluating the quality of care that we provide. For example, Rehability may use your personal health information to contact you for appointment reminders, information about treatment alternatives, or other health related benefits that could be of interest to you.

Rehability may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, and for emergencies. We may provide de-identified information for research studies. We may also provide information when required by law.

In any other situation, Rehability's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures.

Rehability may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in a common area of our clinic. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment, any administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. Rehability will consider all such requests on a case-by-case basis, but the Company is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you have a complaint, are concerned that Rehability may have violated your privacy rights, disagree with any decisions we have made regarding access or disclosure of your personal health information, or you would like further information on Rehability's health information practices please contact our office at 403 W. Main St., Ste. B, Belgrade, MT 59714. You may also send a written complaint to the US Department of Health and Human Services.