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| ***ENROLLMENT INFORMATION*** | | | | | | | | | | | |
| **First:** | **Last Name:** | | | | | | **M.I.** | | *Nickname (if any):* | | |
| **DOB: Age:** | | **Gender:** MALE or FEMALE | | | | | **SS #** **XXX-XX- \_\_\_\_\_\_\_\_**  ***(Last 4 digits ONLY)*** | | | | |
| **Mailing / Billing Street Address:** | | | **City:** | | | | | | **State:** | **Zip Code:** | |
| **Marital Status: S**ingle **M**arried **W**idowed **D**ivorced | | | | | | | | | | | |
| **Home  Phone:**  **7** | | **Cell  Phone:** | | | **Email:** | | | | | | |
| **Currently No:** *Retired Disabled*  **OR Yes\*:** *Full Time or Part Time*   **Employed:** *Name of Employer:*   **Occupation:** *Employer’s Phone:* | | | | | | | | | | | |
| ***EMERGENCY CONTACT INFORMATION*** | | | | | | | | | | | |
| **Name**: | | | | | **Relationship:** | | | | | | |
| **Phone Number:** | | | | | **Alternate #:** | | | | | | |
| ***PROVIDER CARE INFORMATION*** | | | | | | | | | | | |
| |  | | --- | | **Referring Physician:** | | **Another referral source:** | | | | | | **Reason for therapy (area of the body):** | | | | | | |
| **Are you currently receiving Home Health Care Services:** No Yes\*\* (*If yes, please inform front desk)* | | | | | | | | | | | |
| **Is the nature of your condition / injury or the therapy to be provided related to any MOTOR  VEHICLE / LIABILITY / WORKERS COMP. CLAIM? \_\_\_\_\_\_ No \_\_\_\_\_\_ Yes** \* If yes, please provide Date of Accident \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ .  Is there any pending litigation? \_\_\_\_\_\_No \_\_\_\_\_\_Yes \*\* If Yes, please provide the Name of your Attorney:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_ Case Manager:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |
| ***INSURANCE INFORMATION*** | | | | | | | | | | | |
| **Name Primary Insurance: MEDICARE** | | | | | | | **Insurance Phone #: SEE CARD** | | | | |
| Subscriber’s Name: **REFER TO COPY OF INSURANCE CARD** | | | | | | | | | **DOB:** | | |
| ID #: **REFER TO INSURANCE CARD** | | | | | Group Policy #**: REFER TO INSURANCE CARD** | | | | | | |
| **Name of Secondary Insurance:** | | | | | | | | | | | |
| Subscriber’s Name: **REFER TO COPY OF INSURANCE CARD** | | | | | | | **Insurance Phone #: SEE CARD** | | | | |
| ID #: **REFER TO INSURANCE /CARD** | | | | | Group Policy # **REFER TO INSURANCE CARD** | | | | | | |

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By signing below, I certify that all of the information above (to the best of my knowledge) is true, correct and complete.

**Signature of Patient/Guardian**:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Date: \_\_\_\_\_\_\_\_\_**

 **HEALTH HISTORY FORM**

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| **Printed Name of Patient:** | **DATE:** |
| **Please answer the following question:**  What is your reason for consulting our center? \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Injury**/**Onset \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cause of Injury \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Is this condition related to one of the following? \_\_\_\_\_Work Injury \_\_\_\_\_Motor Vehicle Injury or  \_\_\_\_\_ Liability Claim against another party (lawsuit/attorney involved)?  Have you experienced this before? \_\_\_\_\_ Yes \_\_\_\_\_ No  Have you had recent: \_\_\_\_\_ X-rays \_\_\_\_\_ MRI \_\_\_\_\_ Nerve Conduction Test \_ \_\_Bone Scan *(within last 6 months – 1 year)* Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Have you recently been hospitalized or had surgery? \_\_\_\_\_ Yes \_\_\_\_\_ No  If yes, date and reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| What activities are you having difficulty with now? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *(i.e. self-care, household chores, walking/moving around, lifting & carrying objects, changing positions, hobbies or other activities)*  Activities/sports you participate in: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *(i.e. pickleball, golf, water aerobics, cards, walking, sewing, etc.)*  \*What personal goals/outcomes you would like to achieve? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Are you currently working? \_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Retired \_\_\_\_\_\_ Disabled  If yes, what is your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hours/week \_\_\_\_\_\_\_\_ | | | |
| \*Have you had any falls in the past year? \_\_\_\_\_ Yes \_\_\_\_\_ No   * If yes, how many? \_\_\_\_\_ 1 fall \_\_\_\_\_ 2 or more * Describe any fall-related injuries \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| How would you describe your general health? \_\_\_ Excellent \_\_\_ Good \_\_\_Fair \_\_\_Poor | | | |
| Do you smoke? \_\_\_\_\_Yes \_\_\_\_\_ No If yes, # of years: \_\_\_\_\_ Packs/day: \_\_\_\_\_\_\_\_\_\_\_ | | | |
| Have you ever had physical therapy before? \_\_\_\_\_ Yes \_\_\_\_\_ No   * If yes, approximate date and reason: \_ ­­­­­\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Have you had any Home Health services within the past six (6) months: \_\_\_\_\_ Yes \_\_\_\_\_ No   * If yes, approximate date and reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Printed Name of Patient:** | **Date:** |

 **PRESENT CONDITION: PAIN / TENSION:** Please place an “X” in the area or areas w/here you are experiencing pain / symptoms.

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| **What best describes your symptoms?** (circle all that apply) |
| Sharp Dull Achy Stabbing Burning Radiating Stinging Nauseating   Numbness Tingling Throbbing Weakness **Other**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Is the Pain? \_\_\_\_\_Constant \_\_\_\_\_Intermittent  What increases your pain/symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  What decreases your pain/symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Is your condition? \_\_\_\_\_Improving \_\_\_\_\_Getting Worse \_\_\_\_\_Not Changing |
| **Rate your pain on a scale of 0 – 10**. *(0 being no pain and 10 needs to be taken to the hospital)*  **CURRENT** level of pain? 0 1 2 3 4 5 6 7 8 9 10  Level of pain at its **WORST**? 0 1 2 3 4 5 6 7 8 9 10  Level of pain at its **LEAST**? 0 1 2 3 4 5 6 7 8 9 10 |

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| **Printed Name of Patient:** |
| **YOUR HEIGHT: \_\_\_\_\_\_\_’\_\_\_\_\_\_\_” CURRENT WEIGHT:\_\_\_\_\_\_\_\_\_\_\_ lbs.  MEDICAL HISTORY:** Do you have or have you had any of the following?   *(Check only those that apply to you please)*  \_\_\_\_\_ Anemia \_ \_\_ Low Exercise Level  \_\_\_\_\_ Asthma \_\_ \_\_ Vision problems  \_ \_ Balance problems \_\_\_\_\_ Allergies  \_ \_\_ Coordination problems \_\_ \_\_ Stroke / TIA  \_\_\_\_\_ Bowel/bladder issues \_\_\_\_\_ Parkinson’s Disease  \_ \_\_\_ Cancer: Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ Multiple Sclerosis  \_\_\_\_\_ Depression \_\_\_\_\_ Nausea/vomiting  \_\_\_\_\_ Diabetes: *Insulin Dependent – Y or N* \_\_\_\_\_ Difficulty swallowing  \_\_\_\_\_ Dizziness/fainting/vertigo \_\_\_\_\_ Kidney problems  \_\_\_\_\_ Excessive fatigue \_\_\_\_\_ Headaches   \_\_\_\_\_ Shortness of breath/breathing problems \_\_\_\_\_ COPD  \_\_ \_ High Blood Pressure \_\_\_\_\_ Tuberculosis  \_\_\_\_\_ Low Blood Pressure \_\_\_\_\_ Thyroid problems  \_\_\_\_\_ Heart attack \_\_\_\_\_ Fibromyalgia  \_\_\_\_\_ Heart disease \_\_\_\_\_ Liver/Gallbladder problems  \_\_\_\_\_ PACEMAKER \_\_\_\_\_ High cholesterol  \_\_\_\_\_ Hypoglycemia *(low blood sugar)*  \_\_\_\_\_ Nervousness / Anxiety  \_\_\_\_\_ Osteoarthritis \_\_\_\_\_ Seizures  \_\_\_\_\_ Osteoporosis/osteopenia \_\_\_\_\_ Ringing in ears  \_\_\_\_\_ Rheumatoid arthritis \_\_\_\_\_ Unexplained weight loss  \_\_\_\_\_ Metal Implants \_\_\_\_\_ Difficulty sleeping  \_\_\_\_\_ Hepatitis \_\_\_\_\_ HIV/AIDS  Any condition/concern not listed above? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ |
| List any **Operation/Implants/Replacements** you may have had (or provide separate list):  Type: \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_ \_\_\_  Type: Date: \_\_ \_\_\_\_\_\_\_  Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_ \_\_\_\_\_  Type: Date: \_\_ \_\_\_ \_  Type: Date: |
| List any **Medications** you are taking **along with dosage** OR \_\_\_\_ See attached list of medications  *(please provide separate list)*  Name\_\_ \_\_\_ Dosage \_\_\_\_\_\_\_ \_  Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Dosage \_\_\_\_\_\_\_\_ \_  Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Dosage \_\_\_\_\_\_\_ \_  Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Dosage \_\_\_\_\_\_\_\_ \_  *(Use back side of this sheet if necessary to write out medications).* |

**I have read and reviewed the information herein and represent that my answers are true, correct and complete. I understand that Active Rehab and its health practitioners are relying upon the information in rendering treatment.**

**PATIENT’S SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**



**HIPAA NOTIFICATION OF PRIVACY PRACTICES**

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| **Printed Name of Patient:** |

I understand Active Rehab is required by law to keep my health information confidential. With my consent, Active Rehab may use and disclose protected health information (PHI) about me to carry out treatment, payment, coordination of care, and other healthcare operations. If I wish to know more about its privacy practices, I shall refer to Active Rehab Notice of Privacy Practices for a more complete description of such uses and disclosures. If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

I have the right to review and request a copy of the Notice of Privacy Practices prior to signing this consent. I understand that Active Rehab reserves the right to revise its Notice of Privacy Practices at any time.

I have the right to request a copy of my personal health information.

I have the right to be notified when it has been determined that a breach of my unsecured PHI has occurred.

I understand this authorization is voluntary. According to HIPAA regulations, Active Rehab may not release information about me to my family or friends without my written consent. Active Rehab will discuss health related information to the person I list as my emergency contact.

I may revoke this authorization at any time, provided that I do so in writing.

I am entitled to receive a copy of this authorization.

Active Rehab may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out healthcare operations, such as appointment reminders, insurance issues and any calls pertaining to my care.

Active Rehab may mail to my home or other designated location any items that assist the practice in carrying out healthcare operations such as patient statements and other office communication.

By signing this form, I am consenting to Active Rehab use and disclosure of my protected health information (PHI) to carry out treatment, payment, coordination of care and other healthcare operations.

Any concerns I have regarding any violation of my privacy rights will be communicated to an Active Rehab Compliance Officer and/or to the Office Manager at Active Rehab. I, also, have the right to report any concerns that I have with my privacy rights to the Office of Civil Rights, U.S. Department of Health, and Human Services.

**PATIENT’S SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_**

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| **Printed Name of Patient:** |

**OFFICE POLICIES  
  
  
CONSENT FOR CARE & TREATMENT:** I consent and authorize Active Rehab to perform physical evaluation, Physical Therapy, Strength therapy, exercise, and related services. In so doing, I understand, acknowledge, and affirm services may involve bodily contact, touching and / or direct contact.   
**ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize Active Rehab to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered to Active Rehab.  
**WORKERS’ COMPENSATION CLAIMS:** If you claim Workers’ Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered. You understand that we are required to fully cooperate and communicate with claims adjusters, case managers and Workers’ Comp. carriers. **CANCELLATION & NO-SHOW POLICY: Please be aware that we require 24-hour notice for cancelling or rescheduling an appointment. The charge for cancellation without proper notice is $25 for per physical therapy visit. This charge will not be covered by nor billed to insurance and will have to be paid by you personally prior to receiving additional treatment. If sick/ill/fever – please call the office to cancel. No fee imposed.**   
**FINANCIAL POLICY:** As a courtesy to you, we will bill your insurance carrier(s). You are responsible for your bill. If you change insurance coverage while undergoing treatment, it is your responsibility to notify the office of this change. If your insurance carrier does not remit payment to us within 90 days, the balance owed will be due in full from you. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. **If any payment is made directly to you by the insurance company for services billed by us, you recognize** an **obligation to promptly remit the payment(s) to us.** If formal collection procedures become necessary, you will be responsible for additional costs incurred. Your insurance benefits as quoted to us by your insurance carrier have been reviewed with you. **We assume no liability for any errors made by your insurance carrier in this quotation. We have reviewed these benefits with you and you agree to pay your portion of this bill. For any questions or concerns regarding your insurance coverage, you are strongly encouraged to contact your insurance company directly and inquire about your benefits. ACTIVE REHAB DOES ACCEPT MEDICARE’S ASSIGNMENT.**

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| INSURANCE VERIFICATION / FINANCIAL RESPONSIBILITY PLAN YEAR 2022 |
| **AT THIS TIME, WE DO NOT ANTICIPATE ANYTHING AT TIME OF SERVICE FOR THE PATIENT.** |
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**I understand the quote of financial responsibility as outlined above. I agree to pay all Co-payments at the time of service OR deductible and co-insurance upon receipt of a statement from Active Rehab. I agree to pay my portion of this bill. Payment is due at the time that services are rendered unless prior arrangements have been made in writing.**

**PATIENT’S SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_**

Acknowledgement – Medicare & Physical Therapy

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| **Printed Name of Patient:** |

It is important to understand some basic facts about how Medicare handles out-patient therapy. Congress determines, through legislation, the way Medicare handles out-patient therapy services.

* Medicare requires that physical therapy be furnished under the order of a physician.
* The physician who writes the order/prescription for your therapy must periodically sign off on therapy notes that we provide.
* The therapist and referring physician will attest for the medical necessity of therapy services via script and signature on supporting documents.
* Medicare considers paying 80% *(after deductible*) of physical therapy services that are reasonable and medically necessary.

1. **Medicare will NOT pay for out-patient therapy and Home Healthcare at the same time; regardless of diagnosis/condition).**
2. **Medicare does NOT allow a patient to have more than one physical therapy provider at the same time. You MUST notify us immediately if you go under Home Health care.** **Failure to notify us (in advance of treatment) will likely result in your being financially responsible for all charges.**

**\*\* Medicare law no longer limits how much they will pay for medically necessary outpatient therapy services in one calendar year.** However, Medicare continues to monitor the amount of therapy services used per calendar year.

**Informed Consent**

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| **Printed Name of Patient:** |

I seek the services of Active Rehab and its employees (“Active Rehab”). I am executing this consent to confirm my discussion with Active Rehab and understanding of the risks, benefits and alternatives to treatment by Active Rehab.

1. **Benefits of Treatment by Active Rehab**

I understand that services and treatments offered by Active Rehab are intended to help me recover, maintain and enhance my ability to live an active, independent lifestyle.

1. **Risks**

I understand that the treatment, modalities, and equipment employed by Active Rehab may carry certain risks. I understand that the physical response to a specific treatment can vary widely from person to person and that it is not always possible to predict an individual’s response to a given modality or procedure. I understand that the services I receive from Active Rehab may cause discomfort, pain or injury or may aggravate a previously existing condition. I understand that if I have any questions or concerns about the services I receive from Active Rehab, I should raise these with my physical therapist or another Active Rehab representative.

1. **Alternatives**

I understand that my health care provider may recommend alternatives to services from Active Rehab to help me meet my health goals, and that if desired, I should ask my health care provider for more information about alternatives to physical therapy.

1. **Representatives**

I understand that Active Rehab makes no representations, claims or guarantees that my medical or health problems or conditions will be helped by undergoing treatment or services with Active Rehab. I understand that my failure to comply with treatment recommendations may impede results.  
I am responsible to disclose to Active Rehab all medications, care and assessments that I receive elsewhere and to provide medical records as needed from other providers to ensure that care is coordinated and compatible.   
I understand that my treatment with Active Rehab may include recommendations that I seek other types of treatment or services from other health professionals who are not affiliated with Active Rehab. I understand that Active Rehab does not supervise these professionals and is not responsible for them.

**I certify that I have read and understand the foregoing Informed Consent. If its contents have raised any questions for me, I have asked and received satisfactory answers to my questions. I hereby agree and accept all of the terms above.**

**PATIENT’S SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_**