

Total Rehab Physical Therapy

Today's Date _____

Patient Information

Name _____
First MI Last

Address _____
Street City State Zip

SS# - - Gender: M F Marital Status: M S D W Date of Birth: _____

Home Phone _____ Cell Phone _____

How did you hear about us? _____ E-Mail: _____

Are you currently under Home Health Care? Y or N

<u>Employment Related</u>	<u>Automobile Accident</u>	<u>Other</u>
Circle: Y or N If yes, date of injury: _____	Circle: Y or N If yes, the date occurred and what state: _____	

Employer Information

Occupation _____ Student: Part or Full Time

Employer _____ Work Phone _____

Address _____
Street City State Zip

Physician Information

Primary Care Physician Name _____

Phone - - Fax - -

Referring Physician Name _____

Phone - - Fax - -

Return Visit Date: _____

In Case of Emergency Information

Name _____ Relationship to patient _____ Phone # _____

Total Rehab Physical Therapy

Name _____ Date _____

Past Medical History: *Please check appropriate answer*

	Yes	No	Comment
Heart Attack / Congestive Heart Failure	___	___	_____
Irregular Heartbeat / Pacemaker	___	___	_____
Cancer	___	___	_____
Diabetes	___	___	_____
Seizures	___	___	_____
High Blood Pressure	___	___	_____
Current Pregnancy	___	___	_____
Metal Implants	___	___	_____
Ulcers	___	___	_____
Arthritis	___	___	_____
Breathing Problems	___	___	_____
Recent Weight Loss / Gain	___	___	_____
Allergies	___	___	_____
Headaches	___	___	_____
Bowel / Bladder Problems	___	___	_____
Other Medical Conditions/surgeries: _____			_____

History of Present Injury / Illness: *Please circle the appropriate response*

1. Onset of illness was:	Gradual	Sudden	
2. Was there trauma involved?	Yes	No	
3. Have you had a previous episode of this problem?	Yes	No	
4. Are your symptoms getting:	Better	Worse	Same
5. Have you experienced any of the following recently?	Dizziness	Headache	Nausea
	Numbness	Tingling	Spasms
6. Is your pain:	Constant	Occasional	
7. What relieves your pain?	Rest	Medications	Heat
	Ice	Walking	Other
8. What makes your pain worse?	_____		
9. Does coughing or sneezing affect your pain?	Yes	No	
10. Have you had physical therapy in the past?	Yes	No	
	If yes, for what? _____		
11. Have you had physical therapy in the past 60 days?	Yes	No	
12. Have you been seen by a chiropractor in the past?	Yes	No	
	If yes, what for? _____		
13. Do you have a current exercise or fitness program?	Yes	No	

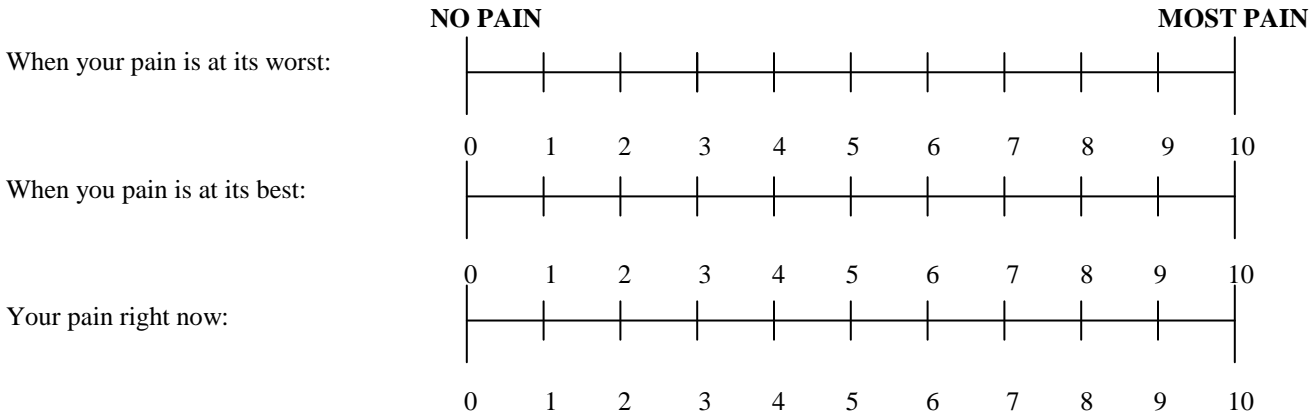
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Total Rehab Physical Therapy

Name _____ Date _____

14. Have you fallen in the last 12 months? Yes No
- If yes, how many times? _____
- Did the fall result in any injury? _____
- If yes, what was the injury? _____
- Why are the falls occurring? _____
15. How are you sleeping? Good Fair Poor
16. What is your energy level? Good Fair Poor
17. How are your eating habits? Good Fair Poor

Please mark on the line where your pain falls:



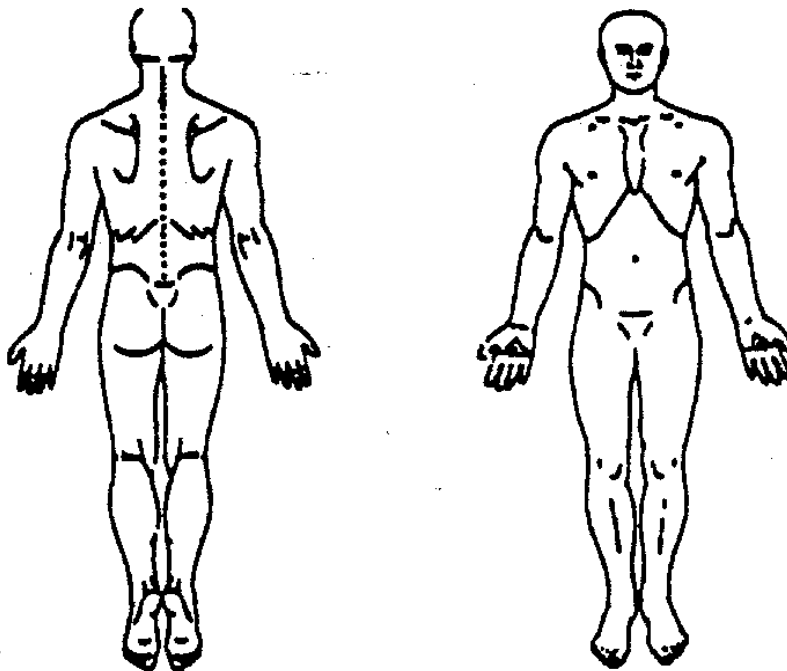
Pain Drawing:

Please be sure to fill this out accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate symbol(s), mark areas of radiating pain and include all affected areas.

Pain XXXXXX

Numbness +++++

Tingling ooooo



Total Rehab Physical Therapy

Consent to Treatment

By signing at the bottom of the page, I hereby authorize the professional staff at **Total Rehab Physical Therapy** to examine and treat me with physical therapy for the injury I have been referred here for or referred myself to. I also give assignment and instruction for direct payment to **Total Rehab Physical Therapy**.

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO HEALTH PROVIDER

Insurance Company/Companies Name(s) _____

I hereby instruct the above named insurance company/companies to pay by check made out to and mailed directly to: Total Rehab Physical Therapy for professional or medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy. I understand that **Total Rehab Physical Therapy** complies with HIPPA and will protect my Protected Health Information (PHI) and will use it as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed and full payment is received. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney for the purpose of securing payment under this policy of insurance or to any Medical Provider associated with my case to effectively treat me. The authorization is in effect until 90 days from the date the last bill is collected.

HIPPA REGULATIONS A photocopy of this Assignment shall be considered effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance under the HIPPA guidelines.

Patient Signature

Date

Patient Printed Name

Staff Witness Signature

Parent or Guardian Signature (if under 18)

Date

Parent or Guardian Printed Name

Staff Witness Signature

Total Rehab Physical Therapy

HIPAA Notice of Privacy Practices

Total Rehab
2515 E Glenn Ave. Suite 104
Auburn, AL 36830
334-821-2256

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

Total Rehab Physical Therapy

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature _____ Date _____

Total Rehab Physical Therapy

Insurance Information

Primary Health Insurance Information

Health Insurance Co Name _____ Ins Phone # _____

Group Number _____ ID Number _____

Primary Insured Name _____ Insured Date of Birth _____

Relationship to insured _____ Insured Phone # _____

Insured Address if Different from Patient:

Address _____
Street City ST Zip

Secondary Health Insurance Information

Health Insurance Co Name _____ Ins Phone # _____

Group Number _____ ID Number _____

Primary Insured Name _____ Insured Date of Birth _____

Relationship to insured _____ Insured Phone # _____

Insured Address if Different from Patient:

Address _____
Street City ST Zip

Worker Compensation/Motor Vehicle Claim Information

Claim Number _____ Name of Employer at time of injury _____

Have you completed and returned a Personal Injury Protection application to insurance company? _____

Insurance Company Name _____

Address _____
Street City ST Zip

Phone _____ Fax _____ Claims Adjuster _____

ATTORNEY: Name _____ Phone # _____

Attorney address: _____