

Patient History



Patient Name: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Patient Occupation \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Date of first MD visit for this problem or injury \_\_\_\_\_ Follow-up MD visit for this problem \_\_\_\_\_

Is this a work injury? Yes No Is an Attorney involved: Yes No

Date of Injury or onset of symptoms \_\_\_\_\_

How did your symptoms begin (gradually, suddenly, injury specifics)? \_\_\_\_\_

Have you had surgery for this problem/Injury: Yes No Type of Surgery \_\_\_\_\_ Date of Surgery \_\_\_\_\_

List your current medications. Include prescriptions, over-the-counter, herbs, and vitamins.

Table with 6 columns: Medication, Dosage, frequency & route, Medication, Dosage, frequency & route. Includes multiple rows for listing medications.

Are you allergic to any medications or latex? If yes please specify \_\_\_\_\_

Please list symptoms you are currently having (pain, swelling, weakness, etc) \_\_\_\_\_

Body Chart: Please mark the areas on the chart where you feel pain. Includes anatomical diagrams of a male and female figure and a pain level scale from 0 to 10.

What is your main complaint? \_\_\_\_\_

Check all the activities that you have trouble performing as a result of your present condition.

- Checklist of activities: Bathing, Child Care, Dressing, Eating, Homemaking, Yard work, Sitting, Sleeping, Standing, Walking, Working.

Table for tolerance: How Long can you tolerate the following? Rows for Walking, Sitting, Standing. Columns for Less than 30 min, 1-2 hours, 3-4 hours, No problems.

What treatment have you previously received for this injury/episode? Physical Therapy, Occupational Therapy, Chiropractic Care, Surgery, Medications, Other.

Please circle if you have had any of these test done for this injury/episode: Bone Scan X-Ray MRI CAT Scan EMG- NCV Myelogram Other

- Do you have or have you had any of the following? List of medical conditions including Asthma, Blood clot, Heart Attack, Diabetes, etc.

If Female: Are you Pregnant? Yes No Do you smoke? Yes No

List any other information that would assist us in your care: \_\_\_\_\_ Are you aware of what your diagnosis is? Yes NO Based on your awareness, what are your expectations/goals while in this program? \_\_\_\_\_

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_



PATIENT NAME \_\_\_\_\_ Patient Date of Birth \_\_\_\_\_

**Consent for Care and Treatment**

I give my consent for treatment by the staff at PREMIER REHAB for physical therapy services and necessary treatment considered medically necessary as prescribed by my physician.

I understand that it is my responsibility to immediately communicate any difficulties and concerns that I have regarding my therapy to the staff at PREMIER REHAB.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Benefit Assignment/Release of Information**

I hereby authorize assignment of my insurance benefits to be paid directly to **PREMIER REHAB** for medical benefits to which I am entitled, including Medicare, private insurance, and third party payers for services performed during the course of my treatment.

I authorize Premier Rehab to release all information necessary including medical records to secure payment for Physical Therapy services provided by Premier Rehab staff.

PREMIER REHAB will use and disclose your personal health information to treat you, to receive payment for the care we provide and for other healthcare operations. *Healthcare operations generally include those activities we perform to improve quality of care.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Appointment/Cancellation Policy**

Premier Rehab requires that all appointments be cancelled and/or rescheduled within 24 hours of your scheduled appointment time. If you cancel with less than 24 hours notice or fail to keep an appointment, you will be charged a \$25 no-show/late cancellation fee which is due prior to your next scheduled appointment.

**Financial Policy Statement**

- We bill insurance carriers solely as a courtesy to the patient
- The patient is financially responsible for services rendered regardless of insurance coverage
- Payment is due at each visit as determined by your benefits
- If any payment is made directly to the patient for services billed by PREMIER REHAB, the patient recognizes an obligation to promptly submit the same payment to PREMIER REHAB.
- It is the patients' responsibility to inform our staff if there is a change in insurance coverage and or contact information to include address and contact phone numbers.
- **If a payment is made in the form of a check and the check is dishonored or returned for any reason there will be a processing fee of \$40.00 per check plus the original amount of each check.**

**I have read and understand my responsibilities for the payment of my account.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

PREMIER REHAB representative/witness \_\_\_\_\_ Date \_\_\_\_\_

- Appointments are scheduled 1-2 weeks in advance. It is your responsibility to make sure appointments have been made. Also please be sure to specify land or pool when making your appointments.



**Notification of Patient Responsibility for co-payments/Co-percentages and Deductibles**

Your insurance company requires PREMIER REHAB to collect your co-payments/co-percentages and any unmet deductible amount from you at the time of service. If we do not collect these amounts we could be in violation of our contract with your insurance company and risk being denied reimbursement for your treatment.

**Benefits as Quoted by your insurance plan:**

1. Deductible Amount **\$ 162.00** Amount met \$ \_\_\_\_\_  
Co-percentage **20% of Medicare-approved amount**
2. **Maximum dollar amount per Medicare is \$ 1,870.00 per calendar year.**  
**This includes Physical Therapy and Speech Therapy.**

**PLEASE NOTE: Medicare has set a cap of \$1,870 but services provided must be considered Medically Necessary by your insurance company for services to be covered and considered for payment.**

**Please read:**

- These quoted benefits are not a guarantee of payment.
- If you have a secondary or tertiary insurance we will forward the claims for payment as a courtesy to you. This does not guarantee that you will not be financially responsible for any amounts left unpaid by either insurance plan.
- You the patient are responsible for payment of services rendered if your insurance denies payment due to exceeding your Medicare cap limit. *Exceeding your therapy cap may occur if you attend several facilities within the same year or if you attend therapy to many times within the same year.*
- You the patient are responsible for payment of services if you fail to respond to insurance requests for additional information that may lead to the denial of your claims.
- The patient is financially responsible for services rendered regardless of insurance coverage

**Please list your health insurance plans:**

Primary \_\_\_\_\_ Secondary \_\_\_\_\_ Tertiary \_\_\_\_\_

**We highly recommend that you call your insurance to verify your Physical Therapy benefits.**

<p>Have you had any Physical Therapy or Speech Therapy in 2011? Yes No</p> <p>If yes, how many visits? _____ Staff initial _____</p>
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**By signing below you acknowledge having read this form in its entirety and fully understand your financial responsibilities as a patient.**

Patient Name (Printed)	Signature	Date
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**Home Health Care Services/Hospice**

These types of services are subject to the home health/Hospice consolidated billing provision

- Skilled nursing care
- Hospice
- Home health aide services
- Physical Therapy
- Speech-language pathology
- Medical social services
- Routine and non-routine medical supplies
- Medical services provided by an intern or resident-in-training of a hospital under an approved teaching program of the hospital in the case of an HHA that is affiliated under the common control with that hospital.
- Care for homebound patients involving equipment too cumbersome to take to the home.

Per Medicare: Since Medicare payment for services subject to home health consolidated billing is made to the primary Home Health Agency, Part B providers or suppliers of these services must be aware that separate Medicare payment will not be made to them.

Are you currently receiving any medical treatment by a Home Health Care Agency or any other medical staff at home including Hospice ? **Yes** **No** Staff Initial\_\_\_\_\_

**If your answer above is YES:**

Please contact your Home Health Care/Hospice provider to arrange Physical Therapy treatment.

If you choose not to have Physical Therapy services provided by your primary Home Health Care Agency and you currently have a Home Health Care/Hospice Episode on file, you the beneficiary will be liable for payment for our services.

\_\_\_\_\_  
Patient Name (Printed) Signature Date

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**RELEASE OF INFORMATION**

I hereby authorize Premier Rehab to release and disclose all Medical History to:

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

I authorize Premier Rehab staff to leave any voice messages regarding appointments and or medical information when medically necessary to the following phone numbers (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_ and (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

**I also understand that I have the right to terminate this authorization at anytime in writing or verbally.**

\_\_\_\_\_  
Patient Name (Printed) Signature Date

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**Please answer:**

Are you currently employed? YES NO If YES FT or PT ?

Is your spouse or other family member currently employed? YES NO If YES FT or PT ?

How many employees work for the employer providing coverage? \_\_\_\_\_

Are you on disability? YES NO Did you sustain an injury while at work? YES NO

Are your injuries related to an accident (i.e. is the pt being treated for an injury for which another party could be liable)? YES NO



## PATIENT RIGHTS AND RESPONSIBILITIES

Patient rights and responsibilities were established with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, family, physician, and facility caring for the patient. Patients shall have the following rights without regard to age, race, sex, national origin, religion, culture, physical handicap, personal values or belief systems.

### THE PATIENT HAS THE RIGHT TO:

- Receive the care necessary to help regain or maintain his or her maximum state of health and, if necessary cope with death.
- Expect personnel who care for the patient to be friendly, considerate, respectful and qualified through education and experience and perform the services for which they are responsible with the highest quality of service.
- Expect full recognition of individuality, including privacy in treatment and care. In addition, all communications and records will be kept confidential.
- Complete information, to the extent known by the physician, regarding diagnosis, treatment and prognosis, as well as alternative treatments or procedures and the possible risks and side effects associated with treatment.
- Be fully informed of the scope of services available at the facility, provisions for after hours and emergency care and related fees for services rendered.
- Be a participant in decisions regarding the intensity and scope of treatment. If the patient is unable to participate in those decisions, the patient's designated representative or other legally designated person shall exercise the patient's rights.
- Refuse treatment to the extent permitted by law and be informed of the medical consequences of such refusal. The patient accepts responsibility for his or her actions should he or she refuse treatment or not follow the instructions of the physician or facility.
- Approve or refuse the release of medical records to any individual outside the facility, except in the case of transfer to another health facility, or as required by law or third party payment contract.
- Be informed of any human experimentation or other research/educational projects affecting his or her care or treatment and can refuse participation in such experimentation or research without compromise to the patient's usual care.
- Express grievances/complaints and suggestions at any time.
- Change primary or specialty physicians or dentist if other qualified physicians or dentists are available.
- Have an advance directive, such as a living will or healthcare proxy. A patient who has an advance directive must provide a copy to the facility and his or her physician so that his or her wishes may be known and honored. Surgery centers and diagnostic imaging centers may be exceptions to this statement and will have a facility-specific policy.
- Be fully informed before any transfer to another facility or organization.
- Express those spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of medical therapy for the patient.

### THE PATIENT IS RESPONSIBLE FOR:

- Being considerate of other patients and personnel and for assisting in the control of noise, smoking and other distractions.
- Respecting the property of others and the facility.
- Reporting whether he or she clearly understands the planned course of treatment and what is expected of him or her.
- Keeping appointments and, when unable to do so for any reason, for notifying the facility and physician.
- Providing caregivers with the most accurate and complete information regarding present complaints, past illnesses and hospitalizations, medications, unexpected changes in the patient's condition or any other patient health matters.
- Observing prescribed rules of the facility during his or her stay and treatment and, if instructions are not followed, forfeiting the right to care at the facility and being responsible for the outcome.
- Promptly fulfilling his/her financial obligations to the facility.

X

Signature

Date