TU REHAB
Outpatient Physical Therapy

Demographic information

NAME_____

DOB_____SS#_____

Home Address_____ City _____ State_____ Zip Code _____

Home Number_____ Cell Number_____ Email _____

Emergency Contact_____ Relationship_____ Phone #_____

Insurance Information

Insurance Name_____ Insurance ID # _____Group #_____

Subscriber name (if different then patient) _____ Subscriber relationship_____

Secondary Insurance Name_____ Insurance ID # _____

Subscriber name (if different then patient) _____ Subscriber relationship_____

- **Is the injury related to a car accident? _____ If yes please inform your therapist**
- **Is the injury related to a work accident? _____ If yes please inform your therapist**
- **Are you currently being seen by another Physical Therapist or Chiropractor? _____**

Referring Physician Information

NAME: _____ Phone Number _____

Referral Source

Kindly let us know who to thank for referring you:

☐ **Physician (name) _____**
☐ **Advertisement (please specify) _____**
☐ **Previous Patient, Friend or Relative (name) _____**
☐ **TU Employee (name) _____**
☐ **Internet** (which site) _____
☐ **Returning Patient** (when were you last seen) _____
☐ **Drive by (sign)**
☐ **Other _____**

TU REHAB
Outpatient Physical Therapy

History and Physical:

To ensure you received a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question, leave it blank and your therapist will assist you. Thank you!

Patient Name _____ Date of Birth _____

Allergy History: (medications and others ex: food, latex) / drug sensitivity:_____

_____

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

Date: _____/_____/_____Procedure: _____

List any Prescription or Non-Prescription medications you are currently taking: _____

_____

FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO

Have you EVER been diagnosed as having any of the following conditions?

	NO	**Yes (onset)**
Asthma/Bronchitis/Emphysema		
Chest pain/Shortness of Breath		
Pacemaker		
High/Low Blood Pressure		
Heart Attack/ Heart Surgery, Heart Disease/Angina		
Blood Clot/ Emboli		
Stroke /TIA		
Parkinson's Disease		
Pins or Metal Implants		
Diabetes		
Infectious Disease		
Cancer/Radiation		
Arthritis		
Osteoporosis		
Hernia		
Epilepsy/Seizures		
Thyroid Condition		
Multiple Sclerosis		
Severe or Frequent Headaches		
Vision or Hearing Difficulty		
Numbness or Tingling		
Dizziness		
Weakness/Energy Loss		
Recent Weight Gain/Loss		
Other		

TU REHAB
Outpatient Physical Therapy

Have you had any of the following medical or rehabilitative care for this injury?

	NO	Yes (When?)
Chiropractor General		
Practitioner Orthopedist		
Physical or Occupational Therapy		
MRI, CT Scan, X-ray etc.		
Other		

Please explain in a few words the reason for your visit: _____

_____

Please describe any other current or previous illness, injury, or health history information your doctor of physical therapy should be aware of prior to his/her comprehensive evaluation:

_____

Pain

Please circle your average pain on the 0-10 scale below

How would you best describe your symptoms? Please circle all that applies below:

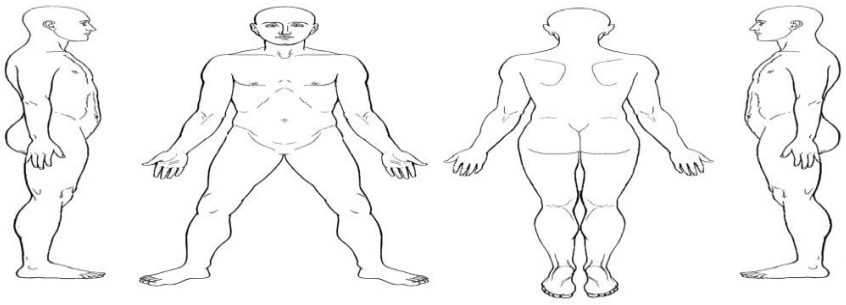
Constant	**Intermittent**	**Variable**	**Unchanging**	
Sharp	**Dull**	**Tight**	**Aching**	**Heavy**
Throbbing	**Tingling**	**Numb**	**Pulling**	**Stabbing**

Pease describe which specific movements/activities worsens or improves your symptoms:

Worsens: _____

Improves: _____

Please mark (X) all the areas you feel symptoms:



Patient Signature: _____ **Date:** _____

TU REHAB
Outpatient Physical Therapy

Financial Agreement & Authorization for Physical Therapy Treatment

We are committed to providing you with the best possible care and 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 our fees financial policy or your financial responsibility.

- **Authorization of Therapy Treatment & Service**

I authorize the staff of TU Rehab to perform examinations and treatments (therapy services) considered necessary and proper by the clinicians as directed and prescribed by my physician.

- **Benefit Assignment**

I hereby assign and authorize payment of medical benefits for any services furnished, including Medicare, Medicaid, private insurance and third-party payers to TU Rehab LLC. I guarantee payment of all charges for services. I understand and agree that if I fail to make any payments for which I am responsible, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

I authorize the release of my medical information to insurance companies, medical and legal authorized personnel. This information will be used for the purpose of evaluating and administering claims of benefits. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself.

- **Self-pay Patients**- Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.
- **Medicare**- We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.
- **Copays**

Payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. You will be responsible for any balance your plan indicates as due on their explanation of benefits form. All patients will be responsible for their co-insurance and deductible.

- **Prescriptions and referrals**

All necessary future prescriptions and referrals required for continued treatment are to be obtained by the patient.

- **Cancellation Policy**

Patients who cancel visits within 24 hours or fail to show up will personally be charged a $25 fee for the visit. This will not be billed to their insurance company.

- **Patients are responsible to bring any insurance payments that may be mailed to the subscriber's/patient's home for payment of services provided by TU Rehab LLC.**

WE ACCEPT CREDIT CARD/CASH OR CHECKS

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

Patient signature_____ Date_____

Parent/Guardian_____Date_____

TU REHAB
Outpatient Physical Therapy

We recognize the sensitive nature of personal health information. We are committed to protecting your privacy as well as your health. Therefore, the following Notice of Privacy Practices describes how medical information about you may be used and is disclosed and how you can get access to this information. Please review it carefully.

USES AND DISCLOSURE OF HEALTH INFORMATION

Pursuant to law, we may use health information about you for treatment (such as sending you medical record information to a specialist physician as part of a referral), to obtain payment for treatment (such as sending billing information to a health insurance plan), for administrative purposes, and to evaluate the quality of care that you receive (such as comparing patient data to improve treatment methods).

Although the law does not require that we obtain a signed consent from you for treatment, payment, or healthcare operation purposes, we encourage you to sign a consent so that you are aware of our concern and practices regarding protection of your personal health information.

Our policies and procedures are designed to protect your privacy. We may need to use or disclose identifiable health information about you without your authorization for several other reasons, such as required law. Subject to certain requirements, we may disclose health information for public health purposes, abuse or neglect reporting, auditing purposes, research studies, funeral arrangements, organ donation, workers' compensation purposes, and/or emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. We may also contact you about appointment reminders or treatment alternatives to raise funds. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies in the future. Before we make a significant change in our policies, we will change our notice and post a new notice in the waiting area. You can also request a copy of our notice at any time.

INDIVIDUAL RIGHTS

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or related administrative purposes. If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You have the right to request that your health information be communicated to you in a confidential manner such as sending mail to an address other than your home. If this notice was sent to you electronically, you may obtain a paper copy of the notice.

You may request in writing that we not use or disclose your information for treatment, payments, or administrative purposes or to persons involved in your care except when specially authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it.

COMPLAINTS

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request. Under no circumstances will you be retaliated against for filing a complaint.

TU REHAB
Outpatient Physical Therapy

OUR LEGAL DUTY

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

CONSENT TO USE/DISCLOSE HEALTH INFORMATION FORM

Although TU Rehab LLC is not required by law to obtain a signed consent from you for treatment, payment, or healthcare operation purposes, we encourage you to sign this consent so that you aware of our concern and practices regarding protection of your personal health information.

Please refer to the Notice of Privacy Practices (the "Notice") for details if you wish prior to signing this consent. Please note that TU Rehab LLC reserves the right to change the privacy practices described in the Notice.

By signing this consent, you agree that TU Rehab LLC may use or disclose your protected health information to carry out treatment, payment, or health care operations.

You have the right to revoke this consent in writing, except to the extent that TU Rehab LLC has taken action in reliance on your consent.

ACKNOWLEDGEMENT AND AGREEMENT

I consent to TU Rehab LLC sending protected health information to the insured in the event that I am receiving treatment but am not though insured under my insurance policy. Such information may include, but not be limited to, explanation of benefits ("EOB") or invoices regarding my treatment. I understand that if I do not want such protected information mailed to the insured, then I will notify TU Rehab LLC of my objection and will complete a Request for Restriction of Use and Disclosure form.

In addition, I understand and accept the risk of unintentional disclosure of my protected health information because the treatment area is an open area where I and other patients are treated simultaneously. I understand that some of my protected health may be inadvertently overheard by other patients and/or therapists. I also agree not to disclose any protected health information that I inadvertently overhear about other patients while I am receiving treatment in the open treatment area.

I have received a copy of TU Rehab LLC's Notice of Privacy Practices.
I hereby certify that I have read the provisions set forth in this consent. I understand and agree to the terms of this consent.

_____
Print Patient's Name

_____ _____
Signature of Patient or Representative Date

_____ _____
Name of Personal Representative (if applicable) Relationship to Patient

I consent to TU Rehab LLC releasing my protected health information to the following individuals:

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____