Patient Information:

Male_____ Female_____

First Name: _____Last Name: _____Middle Initial_____

Address: _____ City: _____ St: _____ Zip: _____

Home Phone: _____ Cell Phone: _____Email: _____

DOB: _____ SSN: _____ Married _____ Single _____

If patient is a minor, Financially Responsible Party (Who will be responsible for charges incurred)

Name: _____ Phone #: _____DOB _____

Relationship: _____ Address: _____

Emergency Contact: _____ Phone Number: _____

Relationship to Patient: _____

Insurance Information:

Insurance Company: _____ ID#: _____Group # _____

Name Policy Under: _____ SS#: _____ Rel to Pt: _____

Secondary Insurance: _____ID#:_____Group#:_____

Name Policy Under: _____ SS#: _____ Rel to Pt: _____

Employer: _____ Work Phone: _____

Address: _____ City: _____ St: _____Zip: _____

Name of Referring Physician: _____ Phone #: _____

Chief Complaint: _____ Date of Injury: _____

How did you hear about our clinic? _____

Have you received physical/occupational/speech therapy during this calendar year? : Yes _____ No _____

If yes, which service and where? _____

Personal Injury Cases Only:

Motor Vehicle Accident: Yes _____ No _____

Auto Insurance Carrier/Attorney Name: _____ Phone#: _____

Contact Name: _____ Address: _____

Claim #: _____ Are you using Med-Pay? _____ Balance? : _____

Work Related Injury: Yes _____ No _____

Insurance Carrier: _____ Claim #: _____

Contact Person: _____ Phone #: _____

DONOHUE&TRAHAN
PHYSICAL THERAPY &
REHABILITATION CENTER

Patient Consent for Use and/or Disclosure of Protected Health Information

1. I understand that as part of my health care treatment, Physical Therapy and Rehabilitation Center ("PTRC") develops and maintains records containing my health information, which includes information about my health history, symptoms, test results, diagnosis, treatment, and claims and payment history, etc. I understand that my health information will be used and disclosed by PTRC for Treatment, Payment, and Health Care Operations, and serves as:
    - public health reporting;
    - a basis for planning my care and treatment;
    - a means of communicating among health professionals who may contribute to my care;
    - a source of information to bill for health care services rendered;
    - a means by which an insurance company or other third party payor can verify that services billed were actually provided; and
    - a resource for "health care operations", such as assessing quality of care and reviewing the competence of health care professionals.

2. I have been provided with PTRC's Privacy Notice, which provides a more complete description of the use and disclosure of my health information. I understand that I have the right to review the Privacy Notice prior to signing this Consent form. I understand that PTRC can change the terms of the Privacy Notice and that PTRC reserves the right to make the new Privacy Notice provisions effective for my health information that it already maintains and uses, as well as for any health information that it may receive in the future.

3. I understand that if I refuse to sign this Consent form allowing for the use and disclosure of my health information to carry out treatment, payment or health care operations, PTRC may refuse treatment.

4. I understand that I have the right to request that PTRC restrict how my health information is used or disclosed to carry out treatment, payment or health care operations, PTRC may refuse treatment.

5. I understand that I may revoke this Consent at any time by notifying PTRC in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation.

_____ _____

Signature of Patient/Patient's Representative Date

_____

Printed Name of Patient's Reprehensive (if applicable)

_____

Representative's Relationship to Patient (if applicable)

If you believe that your privacy rights have been violated or that we have violated our own privacy practices, you may file a complaint with us. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201. Complaints filed directly with the Secretary must be made in writing, naming us, describe the acts or omissions in violation of the Privacy Rules or our privacy practices, and must be filed within 180 days of the time you knew or should have known of the violation. Complaints submitted directly to us must be in writing and to the attention of our Privacy Officer. There will be no retaliation for filing a complaint.

BY SIGNING BELOW, I HEREBY ACKNOWLEDGE RECEIPT OF THIS PRIVACY NOTICE:

_____ _____

Printed Name of Patient Date

_____

Signature of Patient or Patient's Representative

_____

Printed Name of Patient's Representative (if applicable)

_____

Representative's Relationship to Patient (if applicable)

To Be Completed by PTRC:

After a good faith attempt to obtain an Acknowledgment of receipt, the patient or representative refused or was unable to sign the Privacy Notice for the following reason(s): _____

_____

_____.

_____ _____

Signature of PTRC Representative Date

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PHYSICAL THERAPY &
REHABILITATION CENTER

Insurance Disclaimer

Please be advised that we will submit your charges for services at Physical Therapy and Rehabilitation Center to your health insurance. It has been our experience that some health insurance companies will not pay for the charges if the injury is related to an accident. We are NOT saying that your insurance will not pay the charges but there might be the possibility that they will refuse to cover your therapy treatments because someone else may be responsible for the charges. If this situation does occur, we will notify you. Information about the accident is very important. If your health insurance company refuses to pay for the charges, you might have the option of submitting the charges to the insurance company at fault. In order for PTRC to file your claims, we must have this information on file. It is your responsibility to provide this information to us. If this information is not provided to us, you will be responsible for the full amount of the charges for your therapy.

In an effort to help you understand your insurance policy, we will call your insurance company to verify your benefits. We try very hard to get accurate information but every policy is different. Sometimes the information that we receive when verifying benefits is not what the insurance company actually pays. Please understand that when we speak to the companies, there is always a disclaimer – VERIFICATION OF YOUR INSURANCE COVERAGE IS NOT A GUARANTEE OF PAYMENT OF YOUR CLAIMS. FINAL DETERMINATION OF PAYMENT IS BASED UPON YOUR CLAIMS BEING PROCESSED BY THE INSURANCE COMPANY.

Print Name: _____

Signed: _____

Date: _____

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PHYSICAL THERAPY &
REHABILITATION CENTER

CANCELLATION AND NO SHOWS

The following are our policies regarding cancellations and no-shows. We take this subject seriously at our clinic, because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and/or your therapist has prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your therapist's instructions and we will be able to help you achieve your goals in treatment.

- We require 24-hour notice in the event of a cancellation. It is your responsibility when you call in to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible.
- There is a $15 charge for a cancellation without proper notice (less than 24 hours). This charge will not be covered by insurance or attorney, but will have to be paid by you personally.
- For Workman's Compensation and Personal Injury patients, documentation of any missed appointments is forwarded to your Case Manager and Primary Physician and this could jeopardize your claim. For Medicaid Patients, this will be reported to the Department of Health and Hospitals.
- Please understand that your pain will probably increase and decrease as your course of treatment progresses and before it is finally erased. Either condition can seem to be a reason not to come in: a.) you are feeling worse and think the treatment is not working, or b.) you are feeling better and it's a great day to go fishing. Neither of these conditions is legitimate as a reason not to come: a.) if you are in pain, come in and get it fixed, or b.) if you are out of pain, now is the time that we can begin doing some real correction of the underlying causes of your problem, and educate you so you won't re-injure yourself.

When you don't show as scheduled, three people are hurt: YOU because you don't get the treatment you need as prescribed by the doctor and/or PT; THE THERAPIST who now has a space in their schedule since the time was reserved for you personally, and ANOTHER PATIENT who could have been scheduled for treatment if you had given proper notice.

Please cooperate with us in this regard. We're looking forward to working with you.

_____ _____

Patient Signature Date

_____ _____

Interviewer Signature Date

CREDIT AGREEMENT

Physical, Occupational, and Speech Therapy treatments will be rendered only upon proper referral of a licensed physician.

I authorize Physical Therapy and Rehabilitation Center, LLC ("PTRC") to render treatments to myself and authorize the release of any medical information necessary to process this claim. I authorize PTRC to fax or mail any medical information to attorneys or insurance companies if requested. I also authorize payment of medical benefits to PTRC for services performed.

Patient agrees to be responsible for the payment of all sums due for services rendered by PTRC and in the event such sums are not paid as and when due, then such indebtedness shall accrue interest at the rate of twelve (12%) percent per annum from such due date until paid. Should any event of default occur or exist under any of Patient's indebtedness in favor of PTRC, Patient shall pay the then unpaid amount of the indebtedness, in principal, interest, costs, expenses, attorney's fees, and all other fees and charges incidental to collection. Such payment or payments shall be made immediately following demand by PTRC.

I understand that this agreement can only be revoked by written notification to PTRC by the patient, except to the extent for the action that has already been taken by the authorization.

I agree to be bound by the terms of this agreement. Signed this _____ day of _____, _____.

X_____

Signature of patient or person responsible for payment if other than patient

_____

Print Name

DONOHUE&TRAHAN
PHYSICAL THERAPY &
REHABILITATION CENTER

EXPLANATION OF SOCIAL WORKER SERVICES

A Social Worker is a part of the team of health care workers that can be accessed at Physical Therapy and Rehabilitation Center secondary to our classification as an outpatient rehabilitation facility. Medical social workers function as caseworkers that assess patients and family members in the areas of physical, mental, psychological and social needs. A social worker can provide counseling and assistance to patients to help them deal with social, emotional, and cultural problems. They work with doctors to determine the environmental relationships underlying a patient's health problems. They can also help patients understand and follow medical recommendations. They will also be able to provide information regarding available community resources and help with the coordination of patient care with all disciplines of rehabilitation. They can address problems including, but not limited to, family, depression, social problems, behavior management, and third party payer information. They can also help patients and families address feelings, disabilities, and distribution of information on health conditions.

After reading the above services that are available to me:

_____ I **DO NOT** feel that I am in need of social worker services at this time.

_____ I **DO** feel that I am in need of social worker services at this time.

_____ _____

Patient Signature Date

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MEDICARE PATIENTS

1. Do you receive now or have you in the last 12 months received any medical services in your home? _____ Yes _____ No

2. If you answered YES to the above question, what services where rendered?

   _____ Nurse

   _____ Home Health Aide (to help bathe, dress, clean, etc.)

   _____ Physical Therapy

   _____ Occupational Therapy

   _____ Speech Therapy

   _____ Social Worker

   _____ Other

3. Are you still receiving these services? _____ Yes _____ No

4. What was the date of your last visit? _____

5. What is the name of the Home Health Agency that services were rendered through?

   _____

Medicare does not pay for outpatient services if you are currently receiving home health. This does not mean that you cannot get physical therapy or occupational therapy, it just means that you will need to be evaluated at home instead of our office. If you have not been officially discharged from home health on the days that you were evaluated and treated here, you are ultimately responsible for the payment of the charges incurred.

_____ _____

Patients Signature Date

_____ _____

Witness Date