

DATE: _____ NAME: _____ AGE: _____

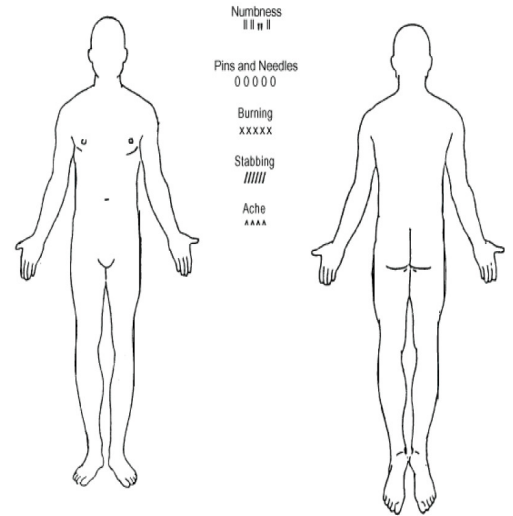
OCCUPATION: _____ CARE GIVER (if any): _____

LIVING SITUATION: (please circle all that apply) alone home stairs # _____

What part of your body is giving you trouble?

Please describe when & how your pain/illness/injury began, including any recent flare ups: _____

List all medications, including over-the-counter & supplemer that you are taking: _____



Medical History: (check all that apply)

High Blood Pressure: _____ Heart Trouble: _____ Pacemaker: _____ Seizures: _____

High Cholesterol: _____ Osteoporosis: _____ Diabetes: _____ Cancer: _____

Rheumatoid Arthritis: _____ Emphysema: _____ Bronchitis: _____ Asthma: _____

Dizziness/Vertigo: _____ **Latex allergy:** _____ Other: _____

Surgeries: (please list all, including metal implants): _____

Do you have problems with decision making, organization, or memory? _____

Are there any cultural customs or traditions you would like us to be aware? _____

Please list all goals you would like to achieve from your physical therapy:

Patient's Signature: _____ Date: _____



Attendance, Co-Pays and Fall Screen

Attendance and Recovery

I understand that my physician has prescribed a treatment frequency of ____ visits a week for a period of ____ weeks and that this is the minimum he or she believes is required for recovery from my functional deficits. I am aware I may jeopardize my recovery if I am unable to make all of my therapy appointments. I further understand that if I do not show up for three (3) scheduled appointments that I risk losing my treatment time slot.

Co-Pays, Deductibles and Visit Limits

I understand that Team Rehab has verified my insurance, and that my insurance requires that Team Rehab collect a co-pay of \$_____per visit.

I would prefer to pay the co-pay: Weekly After each treatment

I understand that my policy may have an out of pocket maximum and that when that is reached I will no longer owe co-pays for the current year. I also understand that the insurance will probably inform me that this maximum has been met before informing providers, therefore I will let Team Rehab know as soon as I receive notification that the out of pocket maximum has been met so that they can stop collecting co-pays.

Currently, my insurance has informed Team Rehab that I have an outstanding deductible of \$_____. This information is frequently out of date as there may be bills from other providers in the payment system. When Team Rehab's first bill is processed, we will know how much of the deductible is truly outstanding. I understand that Team Rehab will then bill me for the outstanding deductible. Team Rehab will never bill me for more than the amount stated above.

Hardship

Current economic conditions in Michigan are difficult. If you are suffering financial hardship, please talk to the clinic director. Your insurance company may allow reduction of deductibles or co-pays in cases of financial hardship.

Fall Risk

As part of a national plan to improve health care quality, Medicare requires PT clinics to screen every patient 65 years or over for risk of falling. Please will you answer the questions below, so that we can comply.

I am under 65. I do not need to answer the questions

Have you fallen and injured yourself at any time in the last 12 months? Yes No

Have you fallen, without injury, twice (2 times) in the last 12 months? Yes No

If the answer to either of these questions is yes, please discuss the circumstances with your PT during your evaluation. You may be at risk of future falls and injuries which may be preventable.

Patient Name: _____ **Signature:** _____ **Date:** _____

Insurance regulations require us to collect this information from you before initiating treatment.

1. Are you working full or part-time with health insurance benefits? Yes No
2. Is your spouse currently working full or part-time with health insurance benefits? Yes No NA
3. Have you recently been laid off? Yes No NA
4. Have you recently lost your job? Yes No NA
5. Have you recently been put on disability? Yes No NA
6. Have you received a Kidney transplant? date:_____
- Maintenance Dialysis? date:_____
- Black Lung benefits? date:_____
- None of the above

7. Is this therapy service for the treatment of an injury which resulted from an
 - Automobile accident?
 - Work-related accident?
 - Not related to an accident?
 (The actual accident may have occurred some time ago.)

If yes, please give details:

When? _____

Where? _____

How? _____

Will you pursue liability? Yes No NA

Insurance company: _____

Name of Policy / Contract holder: _____

Relationship to you: _____

Policy / Contract #: _____

8. Date of Retirement. Patient: _____ Spouse: _____

Patient Name: _____ **Signature:** _____ **Date:** _____

GENERAL CONSENT FOR TREATMENT

CONSENT: I consent to physical therapy treatments as deemed necessary by my doctor and therapist. I understand that while in Team Rehabilitation’s clinics I am under the care of my doctor and my therapist, and that my therapist and any staff assisting him or her will follow a plan of care approved by my doctor.

PAYMENT BY HEALTH INSURANCES: I authorize my health insurance (or Medicare) to make payment for my treatment directly to Team Rehabilitation.

Team Rehabilitation is a participating provider with Medicare, Blue Cross Blue Shield of Michigan, and most health insurers. Thus, Team Rehabilitation accepts payment from all health insurers as payment in full for its services. The only exception is where the insurer requires Team Rehabilitation to collect co-pays and deductibles from the patient. I understand that Team Rehabilitation will never bill me for contractual allowances (sometimes called network discounts) or payments for services that are denied or deemed to be not covered, unless I have agreed in writing, in advance, to pay for those services.

I understand that my contract with my health insurer may specify deductibles and co- pays. I understand that these payments are my responsibility and agree to pay them. I have been informed that Team Rehabilitation will waive all or part of my co-pays and deductibles if I am experiencing financial hardship.

VERIFICATION OF BENEFITS: I certify that the information I have provided to enable Team Rehabilitation to verify my health insurance or Medicare benefits is accurate and complete to the best of my knowledge and belief. I authorize Team Rehabilitation to contact all the payors involved in my case, and to give them all the information they request about my case, in order to verify my benefits.

PRIVACY OF MY HEALTH CARE INFORMATION: Team Rehabilitation makes every effort to comply with State and Federal law on the privacy of health care information. I acknowledge that I have been given a copy of Team Rehabilitation’s HIPAA (Health Insurance Portability and Accountability Act) policy, and have had time to read it and ask for further information.

NO GUARANTEE: I understand that the practice of physical therapy is not an exact science, and that there is tremendous variation between the results achieved by apparently similar patients with apparently similar diagnoses. Therefore, neither Team Rehabilitation nor any of its therapists has made any promise to me concerning the results of my therapy. However, Team Rehabilitation and all its therapists do promise to use their best clinical judgment and their utmost efforts to help me to achieve the best result I possibly can.

PERSONAL PROPERTY: Team Rehabilitation is not responsible for loss or damage to any of my personal property while I am in any of Team Rehabilitation’s clinics.

Signature of Patient: _____ Date: _____

Witness: _____ Date: _____



Team Rehabilitation offers patients the services of a social worker. There will never be a charge to the patient for this service. The social worker can help with the following issues:

- Assistance with applying for benefits, eg Social Security or Medicaid
- Assistance with Worker's Compensation
- Transportation
- Programs for Seniors
- Chore Services
- Meals on wheels
- Therapy Counseling
- Psychosocial Assessment
- Psychiatric Services
- Other community or medical services

Would you like to speak to the social worker?

Yes

No

If you would like to speak to the social worker, how urgently do you need an appointment?

Within 24 hours

Within one week

Not particularly urgent

If you would like to speak to the social worker, please give your contact information.

Same as admissions information

If different from admissions information,

Name: _____

Phone: _____

Best time to be reached: _____

May we leave a message on this phone?

Yes

No