PHYSICAL THERAPY

Relieving Pain, Improving Strength, Restoring Function

Spine, Orthopaedic & Vestibular Rehab

NAME:	DATE OF BIRTH: AGE:
ADDRESS:	SEX (circle one): MALE FEMALE
CITY:	SSN:
STATE: ZIP CODE:	HOME PH: ( )
PRIMARY CARE DR. NAME:	CELL PH: ( )
PRIMARY CARE DR. PH #: ( )	EMAIL ADDRESS:
EMERG. CONTACT NAME:	ATTORNEY'S NAME (if applicable):
EMERG. CONTACT PH #: ( )	ATTORNEY'S PH #: ( )
RELATIONSHIP (check one): _____Husband _____Wife	_____Son _____Daughter _____Other

Please check the appropriate type of claim and complete the corresponding information box below.

_____ WORKERS COMP _____ AUTO ACCIDENT _____ HEALTH INSURANCE

ARE YOU CURRENTLY HAVING, OR HAVE YOU HAD IN THE PAST, HOME HEALTH SERVICES? Y N

PRIMARY HEALTH INSURANCE INFORMATION	
HEALTH INS	SUBSCRIBER
ADDRESS	ADDRESS
CITY	CITY
STATE ZIP	STATE ZIP
GROUP #	Pt's RELATION TO SUBSCRIBER
ID #	SSN OF SUBSCRIBER
TELEPHONE	SUBSCRIBER'S DATE OF BIRTH:

SECONDARY INSURANCE INFORMATION	
HEALTH INS	SUBSCRIBER
ADDRESS	ADDRESS
CITY	CITY
STATE ZIP	STATE ZIP
GROUP #	Pt's RELATION TO SUBSCRIBER
ID #	SSN OF SUBSCRIBER
TELEPHONE	SUBSCRIBER'S DATE OF BIRTH:

WORKERS COMPENSATION OR AUTO ACCIDENT INFORMATION	
SUBSCRIBER	INSURANCE CO.
ADDRESS	ADDRESS
CITY	CITY
STATE ZIP	STATE ZIP
TELEPHONE	TELEPHONE
CONTACT	CONTACT
DATE OF INJURY	CLAIM #

PAYMENT AND STOP-TREATMENT POLICY

IMPORTANT... We can bill your insurance as a courtesy, **but** you are responsible for payment of your bills.
You are responsible to pay for services not paid by your insurance

WE MAY STOP TREATMENT...1) if you are not making adequate progress; 2) if you miss two appointments; if you re-schedule appointments more than twice.

RELEASE OF INFORMATION AND AUTHORIZATION TO PAY

I authorize RCA to release any information necessary to process insurance claims, inform my physician, insurance company, lawyer, case manager, employer or school of my status. I have been informed of RCA's privacy protection policy and understand that RCA will protect my information from unauthorized release. I understand the above payment and stop treatment policies.
I authorize insurance payment to be made directly to RCA. I understand my insurance may not pay for all services and materials and accept responsibility to pay for that which is not paid by insurance.

Signature of Patient:_____ Date:_____

INITIAL HISTORY

Name: _____ Date: ____/____/____ Time: _____
(last) (first)

Birthdate: _____/_____/_____ Age: _____ Referring Physician: _____

Height: _____ _____ Weight: _____ BMI Index: _____
(ft.) (in.)

MEDICAL HISTORY: (please check all that apply)

_____ Heart Disease	_____ Diabetes	_____ High Blood Pressure	_____ Pacemaker
_____ Cancer	_____ Tuberculosis	_____ Visual Impairment	_____ Epilepsy
_____ HIV/AIDS	_____ Arthritis	_____ Hearing Impairment	_____ Fibromyalgia
_____ Stroke	_____ Asthma	_____ Depression	_____ Scoliosis
_____ Osteoporosis	_____ Hepatitis	_____ Pregnant	_____ Other

MEDICATIONS: _____

SURGICAL HISTORY: _____

_____

Are you currently on home health service (please give details, i.e. date range, reason, etc.): _____

_____

Have you had physical therapy for this condition within the last 12 months? Y N Was it effective? Y N

Are you currently receiving other treatments for this condition (i.e. Chiropractor, acupuncture)? Y N

Have you had surgery for your condition? Y N If yes, please give approximate date: _____

Have you had epidural or cortisone injection for this condition in the past? Y N If so, was it effective? Y N

Please check any diagnostic tests you had for this condition: ____ MRI ____CT Scan ____ X-ray

What are your current symptoms? _____

When did the injury or symptoms occur (onset date)? _____

How did the injury or problem occur? _____

_____

Please rate your pain:

0 1	2 3	4 5	6 7	8 9	10
No Pain	Mild Pain	Moderate Pain	Severe Pain	Very Severe Pain	Worse Possible Pain

Where is your pain or problem located? _____

- Is your pain: Constant? Intermittent?

- What makes your pain / problem better? _____ Worse? _____

- Is there pain present at night? Y N What position helps you sleep? _____

Please state your therapy goals: _____

Please complete the following page

CONSENT TO GENERAL CARE

I wish to be treated at Rehabilitation Care Associates, Inc. While I am at the clinic, I permit my doctor, the therapist, anesthesiologist and any of the clinic employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care may include tests, examinations and medical treatment.

VALUABLE AND PERSONAL ITEMS

I understand Rehabilitation Care Associates Inc. will not be liable for loss of dentures, glasses, money, jewelry, documents, clothing or other possessions retained by me and any brought to me while a patient is in the clinic, unless they are delivered to and placed in safekeeping with the clinic.

INSURANCE COVERAGE

In consideration of service rendered or to be rendered, I hereby assign and transfer to Rehabilitation Care Associates Inc. any benefits payable to or for my benefit under clinic visits, sickness or accident insurance and any other insurance coverage to include major medical, for the payment of such services rendered. I agree to cooperate, aide and assist the clinic in procuring all possible insurance benefits including initiation and fulfillment of all policy provisions such insurance companies may require for payment. I further, assign and transfer to aid clinic an interest in any cause of action I may have arising out of injuries directly or indirectly resulting in this period of clinic visitation. This assignment includes Insurance benefits accruing to me under uninsured motorist coverage. This assignment extends to the total amount owed the clinic and also authorizes applicable health benefits, if any, to be paid to the physician-specialists in the field of Neurology, Anesthesiology and any other licensed physicians, individual or groups who perform services for my treatment at Rehabilitation Care Associates Inc.

FINANCIAL RESPONSIBILITY

I understand that regardless of my assigned Insurance benefits, I am responsible for the total charges for services rendered and I further agree, that all amounts are due upon request and are payable to Rehabilitation Care Associates Inc. without relief from valuation and appraisement laws. I further understand, that should this account not be paid when due and it becomes necessary for the account to be referred to an attorney or collection agency for collection or suit, I, as the designated responsible party, shall pay the reasonable attorney fees or collection expense. If I am a Medicaid recipient and request and receive services for which Medicaid will not pay, I understand I must pay for those services.

RELEASE OF INFORMATION

I authorize Rehabilitation Care Associates Inc. to release such medical information as may be required for the payment of claims arising out of the clinic stay when requested by representatives of local, state or federal agencies, insurance companies or other organizations or entities. In addition, I understand that relatives, friends and the media may inquire about or request information relative to my status at the clinic. I authorize Rehabilitation Care Associates, Inc. to provide only te following information: my name, admission or discharge, medical condition in general terms and emergency treatment rendered, if any.

I further authorize Rehabilitation Care Associates Inc. to release any information acquired in the course of my examination or treatment to other providers of health care such as hospitals and/or doctors, visiting nurse associations, home health agencies, nursing homes or other providers of social services actively involved in my prior care, my current care or my subsequent care. I further acknowledge that I have read this document and that I fully understand it.

It is the policy of Rehabilitation Care Associates Inc. to provide services to all persons without regard to race, color, national origin, gender, disability or age. The same requirements are applied to all and there is no distinction on eligibility for or in the manner of providing services.

I understand and agree this document and all issues arising out of my treatment at this clinic, shall be governed by laws of the State of Indiana.

_____ AM/PM

(Patient's Signature) (Date) (Time) (Cross out one)

_____ AM/PM

(Witness) (Date) (Time) (Cross out one)

The patient is unable to consent
Because:_____

I therefore consent for the patient

_____ AM/PM

(Signature) (Date) (Time) (Cross out one)

_____

(Relationship to Patient) (Witness)

NOTICE OF PRIVACY PRACTICE
PATIENT ACKNOWLEDGEMENT

Patient Name: _____ **Date of Birth**_____

I have read/received this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by the practice, my individual rights and the practice's legal duties with respect to my protected health information. The notice includes:

- A statement that this practice is required by law to maintain the privacy to protected health information.
- A statement that this practice is to abide by the terms of the notice currently in effect.
- Type of uses and disclosures that the practice is committed to make each of the following purposes: treatment, payment and health care operations.
- A description of each of the purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of use disclosures that are prohibited or materially limited by law.
- A description of use disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The rights to complain to this practice and to the secretary of HHS, if I believe my privacy rights have been violated and no retaliatory actions will be used against me in the event of such complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information and this practice is not required to agree to requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____
Relationship to patient (if signed by a personal representative of patient):_____

RCA REHABILITATION CARE ASSOCIATES, INC.

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APPOINTMENT CANCELLATION NOTICE

I am aware a charge will be made for cancelled appointments, unless I cancel at least **24** hours prior to my appointment.

I am also aware RCA Physical Therapy has voice mail that is available for my convenience to receive messages 24 hours a day, 7 days a week.

Signature Date