

PATIENT INFORMATION

SSN _____

Patient Account# _____

Last Name _____ First Name _____ MI _____

Address _____ Home Phone _____ Cell _____

PO Box _____ Work Phone _____ Ext: _____

City, State & Zip _____

Sex: Male / Female

Employer _____

Date of Birth: _____

Employer's Address _____

City, State & Zip _____

Marital Status: Married/ Single/Divorced/Widow

Please provide your e-mail address if you would like us to email your home exercises, receive our newsletter or receive event information.

Employed: Full / Part / Not Employed
 Self-Emp. / Ret. / Military

Student: Full / Part / Not a Student

E-mail Address _____

Referring Physician (Last Name) _____ (First Name) _____

Primary Care Physician (Last Name) _____ (First Name) _____

Person to Notify in Case of Emergency _____ Phone _____

Who May We Thank For Referring You? _____

GUARANTOR INFORMATION

Is the Patient Responsible for the Bill? Yes / No If not, Guarantor SSN _____

Guarantor Name _____ Guarantor DOB _____

Address _____ Home phone _____

Guarantor's Employer _____ Work phone _____ Ext: _____

INSURANCE INFORMATION

Primary Ins. _____

Policy Number _____

Secondary Ins. _____

Policy Number _____

Above information reviewed no changes: Initial _____ Date _____ Initial _____ Date _____ Initial _____ Date _____

Financial Statement and Acknowledgement

Financial Statement

As a patient of Integrated Rehabilitation Services, LLC (IRS), your insurance coverage is verified to determine available benefits. Even though this information is reliable, it is not guaranteed. You are responsible for knowing the benefits, limitations, and/or restrictions that your policy may stipulate.

We base our information regarding your insurance coverage on what we are given by your insurance company when we verify your coverage. We then convey this information to you as a courtesy when we file insurance claims on your behalf. The exact determination of benefits occurs at the time your insurance company pays the claim. Every effort will be made to notify you should a difference occur between what was expected and what was actually paid. You do however, receive notification directly from your insurance carrier what they paid to us, and it is reflected on your monthly statement.

We must emphasize that as medical providers, our relationship is with you. While the filing of insurance claims is a service that we extend to our patients, it is your responsibility to see that your charges are paid in full. Any known deductions including deductibles, co-pays, co-insurance, or non-covered services/supplies are due at the time of service. Any amounts rejected for any reason by your insurance company are due at the time of their rejection. Outstanding patient balances over 60 days are subject to an 18% APR finance charge. Delinquent accounts will be referred to our attorney, collection agency, or small claims court.

Patient Acknowledgement

I agree that, all costs incurred for collections including finance charges, collection costs, reasonable attorneys' fees and court costs are my responsibility.

Payment is expected at the time of treatment for all deductibles, co-pays, and co-insurance. Due to carrier requirements for treatment/authorization, failure to provide active coverage prior to your visit will result in your financial responsibility for those services. I understand and agree that I am financially/legally responsible for full payment of my bill for services and that any failure of my insurance carrier to pay for all or any part of my bill does not constitute a reason for me not to pay. I understand that my insurance policy is a contract between me and the carrier, and that Integrated Rehabilitation Services, LLC is not responsible for settling disputed claims. IRS will provide the necessary information regarding my treatment in order to facilitate payment of my claim for benefits.

In addition, I have been advised that my failure and/or denial to provide accurate insurance information prior to, or upon my initial visit constitutes my classification as a self-paying uninsured cash patient. This classification will cause me to forfeit and or relinquish all subsequent discounts, agreements, adjustments, benefits, and arrangements that IRS may have contractually accepted with any or all third party insurance carriers. This will supersede and replace any prior obligation that IRS may have.

In the unlikely event my insurance carrier determines that care provided to me under the referral of my physician is "not medically necessary", I hereby have been provided prior notice that I am fully responsible for any charges not paid by my insurance carrier based on their decision.

I also understand that IRS requires 24-hours' notice for cancellation of scheduled appointments and I may be financially responsible (not my insurance carrier) for late cancellations and missed appointments (no shows).

I have read and understand the Integrated Rehabilitation Services, LLC Financial Statement and Patient Acknowledgement.

Patient/Responsible Party's Signature

Date

Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for **Integrated Rehabilitation Services, LLC**, to furnish medical care and treatment to _____ considered necessary and proper in evaluating and/or treating his/her physical condition.

X _____ X _____
Patient/Guardian/Responsible Party **Date**

Medicare Lifetime Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to **Integrated Rehabilitation Services, LLC**, for any services furnished me by the therapist. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information to determine these benefits payable for related services.

X _____ X _____
Patient Signature **Date**

Private Insurance Authorization for Assignment of Benefits/Information Release

I, the undersigned, authorize payment of medical benefits to **Integrated Rehabilitation Services, LLC**, for any services furnished me by the therapist. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

X _____ X _____
Patient or Parent/Guardian Signature (if child is under 18 years old) **Date**

Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations (HIPAA)

I, the undersigned, understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- *A basis for planning my care and treatment
- *A means of communication among the many health professionals who contribute to my care
- *A source of information for applying my diagnosis and surgical information to my bill
- *A means by which a third-party payor can verify that services were actually provided,
- *A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change its notice and practices and, prior to implementation, will mail a copy of any revised notice to the address that I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I wish to have the following restriction to use for disclosure of my health information:

I, _____ fully understand and ___ accept ___ decline the terms of this contract.
 (Print Patient Name)

X _____ X _____
Patient or Parent/Guardian Signature (if child is under 18 years old) **Date**

Medical History

Name: _____ Have you had any Home Health Care within the past year? YES NO

If you are under the care of a physician, please describe the condition and its duration: _____

OTHER: _____

PAIN SCALE: Please indicate/mark the level of your pain, when it is at its *least* level and *worst* level:

0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____
 No pain at all _____ as bad as it can be

Please check if you have had any of the following within the last year

Please check if any of these are applicable to you

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Bowel problem | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Low Back Pain |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Lost pleasure in things you enjoy | <input type="checkbox"/> Asthma | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Coordination problems | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Muscular dystrophy |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Numbness | <input type="checkbox"/> Broken bones/fractures | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Pain at night | <input type="checkbox"/> Cancer | <input type="checkbox"/> Parkinsons Disease |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Prolonged fatigue | <input type="checkbox"/> Depression | <input type="checkbox"/> Peripheral neuropathy |
| <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Seizures/epilepsy | <input type="checkbox"/> Developmental/growth problem | <input type="checkbox"/> Repeated Infections |
| <input type="checkbox"/> Dizziness or blackouts | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Skin diseases |
| <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Stress/tension | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Stomach problems/ulcers |
| <input type="checkbox"/> Feel down or hopeless | <input type="checkbox"/> Urinary problems | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Fever/chills/sweats | <input type="checkbox"/> Vision problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Weakness in arms or legs | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Are you pregnant? |
| <input type="checkbox"/> Joint pain/swelling | | <input type="checkbox"/> Infectious disease (eg TB, hepatitis) | <input type="checkbox"/> Do you use tobacco? |
| <input type="checkbox"/> Loss of Appetite | | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Do you have Pacemaker/Defibrillator? |

Please list any surgeries you have had _____

Do you have any allergies? If yes, please list : _____

Are you Latex Sensitive? YES NO Are you currently taking any prescription medication? YES NO If yes, please list:

Do you take any blood thinners (e.g. Coumadin, Plavix, etc.)? YES NO

Are you currently taking any non-prescription medication? YES NO Please list: _____

Check if you have seen any of the following providers in this calendar year: Chiropractor Podiatrist Neurologist Orthopedist
 Speech Therapist General Practitioner Rheumatologist Physical Therapist Other: _____

Check if you have had any of the following in the past 3 years: CT scan Myelogram Blood Test EEG Biopsy MRI
 Echocardiogram Pulmonary Function Tests ER Care Angiogram Nerve Conduction Test Stress Test Doppler US
 Mammogram Urine Test

GENERAL HEALTH: (check one) Excellent Very Good Good Fair Poor

Please list any other information that would assist us in your care: _____

Are you aware of what your diagnosis is? Yes No

Based upon your awareness, what are your expectations/goals while in this program? _____

Patient/Guardian signature: _____ Date: _____