New patient Registration

Date:_____ Date of Initial Eval: _____

Patients Name:_____ Diagnosis: _____

DOB: _____ SS#: _____ Phone: _____

Sex: _____ Marital Status:_____ Have you ever been Treated at TRS?___ Where_____

Home Address:_____ City_____ State:_____ Zip_____

Work Address: _____ City_____ State:_____Zip_____

Work Phone: _____Cel:_____

E-Mail:_____

PolicyHolder (PH)_____(PH) SS#_____ (PH) DOB: _____

Referring Physician Name:_____
Address:_____City:_____State:_____ Zip:_____
Phone: _____ Fax:_____

Insurance: _____ Phone _____

Address:_____ City: _____ State____ Zip:_____

Plan _____ Group # _____ ID _____

Provider	Yes/No	HMO:	Yes/No	POS	Yes/No
Medicare Primary:	Yes/No	Motor Vehicle	Yes/No	Worker's Comp	Yes/No
PPO:	Yes/No	Med Pay	Yes/No	Other: _____	

Emergency Contact Name:_____ Relationship:_____
Address:_____City:_____State:_____ Zip:_____
Phone: _____ Work Phone:_____

Reason for today's Visit:_____
_____
Job related?_____ Auto accident? _____Area To be treated:_____
Date of Illness or Injury:_____

Workers Compensation / MVA Only
Adjuster:_____ Phone:_____ Fax:_____
Email:_____Address:_____
Case Mgr:_____ Phone:_____ Fax:_____
Email:_____Address:_____
Policy #_____ Claim#_____ DOI:_____
Pre-Cert Required? Yes/No Pre-Cert # _____ Other:_____
Authorization Given By:_____ Visits Approved:_____
DME Coverage?_____ Limitations:_____
Motor Vehicle Limits: PIP_____ Med Pay_____ Deductible?_____
Transportation? Yes/No Company:_____ Ph:_____

Mailing Address For Claims:_____
_____
_____

Top Section for office use only

In-Network Benefits:_____ Effective Date: _____

Deductible:_____ Amt. Met?_____ Copay/Co-Ins: _____

Out of Pocket Limit: _____ Yearly Max: _____ DME: _____

Yearly Visit Limitation/Other Limits:_____

MCR DED Covered? Yes/No Pre-Auth/Referral Required? Yes/No Auth#_____

Out of Network Benefits:_____ Effective Date:_____

Deductible:_____ Amt. Met?_____ Copay/Co-Ins: _____

Out of Pocket Limit: _____ Yearly Max: _____ DME: _____

Yearly Visit Limitation/Other Limits:_____ MCR DED Covered? Yes/No

Pre-Auth Required? Yes/No Auth#_____ Insurance Pays: Patient/Provider

THERAPEUTIC REHAB SPECIALISTS PAYMENT POLICY

Welcome to Therapeutic Rehab Specialists! We're happy to further extend our services by filing your primary insurance for you. ***Please select*** from the following payment choices:

_____ **SELF PAY: Please pay the balance in full at the time of service. In the event that you are unable to pay the balance in full, please advise us prior to the time of service. Please be advised that we are not a credit grantor, and therefore, failure to maintain these arrangements may result in the placement of your account with an agency or attorney for collection.**

_____ **WORKERS' COMPENSATION: We will bill your Workers' Compensation Carrier for your charges. To the best of our ability, these charges will be pre-approved. Please note that you will remain financially responsible for any and all charges if your carrier denies coverage or your claim is denied.**

_____ **PRIMARY AND SECONDARY INSURNCE: We will bill your primary and secondary insurance carriers. We assume payment of insurance benefits is not forthcoming on charges older than 60 days. Charges outstanding for more than 60 days from the date of filing will be due in full from you regardless of the type of insurance involved. Any overpayments will be refunded after all charges have been fully processed by your insurance carrier.**

PLEASE BE AWARE THAT WE REQUIRE PAYMENT FOR ALL MONIES DUE THAT YOUR INSURNCE WILL NOT COVER AT THE TIME OF SERVICE. IN THE EVENT YOUR ACCOUNT BECOMES DELINQUENT, AND IS THEREFORE IN DEFAULT OF PAYMENT, YOU, THE CLIENT, WILL BE RESPONSIBLE FOR THE PRINCIPAL COLLECTIONS OF THIS DEBT, INCLUDING, BUT NOT LIMITED TO, COLLECTION SERVICE FEES, ATTORNEY' FEES AND ALL COURTS AND ADDITIONAL LEGAL FEES ASSOCIATED WITH THE RECOVERY OF THIS DEBT.

All supplies are payable at the time of service and cannot be charged to your insurance carrier. However, we will file for any covered supplies allowed by your insurance carrier. Supplies are non refundable.

Thank you for allowing us the opportunity to serve you!

I hereby assign all medical benefits to which I am entitled to Therapeutic Rehab Specialists in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owing as well as all reasonable cost associated with the collection of this debt, including, but not limited to, collection service fees, attorney's fees and all court costs and additional legal fees associated the recovery of this debt. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of Therapeutic Rehab Specialists as may be directed by prudent medical practice by my illness, injury or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

Signature_____ **Date:**_____

GENERAL HEALTH QUESTIONNAIRE

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on this form. If you do not understand a question ask your therapist to assist you. Thank You!

NAME:_____ LEISURE ACTIVITIES/ EXERCISE:_____

ALLERGIES: List any medication(s) your allergic to:_____

Are you latex sensitive? Yes or No List any other allergies or sensitivity to <u>any</u> chemical or food we should know about:_____

Do you have any rash, wound, skin condition or infection of any kind at this time? Yes or No If **Yes** Please explain:_____

OCCUPATION:_____ DATE:_____ Height: _____Weight: _____

Please check (/) any of the following whose care you're under:

___ Medical Doctor (MD) ____Psychiatrist/Psychologist Other:_____
___ Osteopath ____ Physical Therapist _____
___ Dentist ____ Chiropractor

If you have seen **any** of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.):_____
_____

Have you **<u>EVER</u>** been diagnosed as having any of the following conditions?

Yes No Cancer, **IF YES**, describe what kind: _____
Yes No High blood pressure
Yes No Heart Problems, **IF YES**, describe what kind:_____
Yes No Circulation problems, (DVT, Bypass)
Yes No Asthma, Emphysema/Bronchitis
Yes No High Cholesterol
Yes No Chemical dependency (i.e., alchoholism)
Yes No Thyroid problems
Yes No Diabetes, (Type I)____, (Type II)____, Do You Take Insulin Y or N
Yes No Gastrointestinal problems, (Crohn's, Colitis, Gall Bladder/ Appendix Surgery.
Yes No Rheumatoid arthritis
Yes No Osteoarthritis, Fibromyalgia, Osteoporosis, Lupus, Scleroderma, Osteomalacia, or Ankylosing Spondylitis
Yes No Depression or Psychiatric Condition, Panic Attacks
Yes No Hepatitis A, B, or C or HIV
Yes No Tuberculosis
Yes No Neurological Condition, (Stroke, M.S., Seizure, A.L.S., Epilepsy, Guillian Barre)
Yes No Kidney Disease, (Infection, Stones, Incontinence)
Yes No Anemia
Yes No Multiple Chemical Sensitivity, Chronic Fatigue Syndrome
Yes No Migraine Headaches
Yes No Prostate Problems (Men) or Gynecological problems (Women)

OVER ≡

Do you have difficulty sleeping? Yes No
During the past month have you been feeling down, depressed or hopeless? Yes No
In the past month have you been bothered by having ↓ interest or pleasure in doing things? Yes No
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? Yes No
Do you have any metal implants or a pacemaker? YES NO If yes, Please state: _____
For Women: *Are you pregnant or think you might be pregnant?* Yes No

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	Reason for surgery/hospitalization	Date	Reason for surgery/hospitalization
1. _____	_____	4. _____	_____
2._____	_____	5. _____	_____
3. _____	_____	6_____	_____

Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains/strains) and the approximate date of injury:

Date	Injury	Date	Injury
1. _____	_____	4. _____	_____
2._____	_____	5. _____	_____
3. _____	_____	6_____	_____

Has anyone in your family (parents, brothers, sisters) ever been treated for any of the following? Please (/)

____ Diabetes ____ Cancer ____ Tuberculosis ____ Arthritis ____ Anemia ____ Heart Disease
____ Headaches ____ High BP ____ Epilepsy ____ Stroke____ Kidney Disease ____ Mental illness

Which of the following *OVER-THE -COUNTER* medications have you taken in the last week?

Yes No Aspirin
Yes No Tylenol
Yes No Advil/Motrin/Ibuprofen
Yes No Laxatives
Yes No Decongestants
Yes No Antihistamines
Yes No Antacid
Yes No Vitamins/supplements (Please List):_____

Please list **<u>any</u> PRESCRIPTION** medication you are taking (including; pills, injections and/or skin patches):

1. _____	_____	4. _____	_____
2._____	_____	5. _____	_____
3. _____	_____	6_____	_____

Please (/) if you have recently noted: _____ Weight loss/gain _____ Nausea/Vomiting _____Fever/chills/sweats _____ Headaches ____ Fatigue/Weakness _____ Numbness or tingling _____ Dizziness _____Bowel/Bladder problems

_____ _____ _____
Patient signature **Date** **Therapist signature**

Therapeutic Rehab Specialists

Supply or Procedure Waiver Form

Date: _____

Patient Name: _____

Uncovered supply or Procedure with Code: _____

Amount Owed by Patient: __$_____

By signing below I understand that the above stated supply or procedure is not covered by my insurance plan through Therapeutic Rehab Specialists. I understand that I will be responsible for the payment in full of the above item at the time of service. I also understand that I agree not to bill the above procedure through my insurance since it is not a covered expense for Therapeutic Rehab Specialists.

Patient Signature: _____ Date: _____

TRS Representative Signature: _____ Date:_____

PATIENT INFORMATION *CONSENT* AND DESIGNATED INDIVIDUALS *AUTHORIZATION* FORM

I have read and fully understand Therapeutic Rehab Specialists' Notice of Information Practices. I understand that Therapeutic Rehab Specialists may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the Company in writing. I also understand that Therapeutic Rehab Specialists will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Therapeutic Rehab Specialists' Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the Company in writing at any time.

I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____

Patient Name

_____ _____

Patient Signature Date

Therapeutic Rehab Specialists

CANCELLATION / NO SHOW POLICY

Therapeutic Rehab Specialists takes pride in providing the highest quality of care for our patients. In order for you to maximize the benefits of your therapy, it is necessary for you to attend all of your scheduled visits as prescribed by your physician.

A 24-hour notice is required for all cancellations so that we may accommodate other patients. Less than a 24 hour notice, or No shows will be charged a fee of $25 per appointment. Please reschedule appointments within the same week.

We thank you for your compliance with this policy. We look forward to providing you with outstanding therapy services with a smile.

Thank you

Therapeutic Rehab Specialists

_____

Patient Initials

THERAPEUTIC REHAB SPECIALISTS, INC.
Notice of Patient Information Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

THERAPEUTIC REHAB SPECIALISTS, INC. LEGAL DUTY

Therapeutic Rehab Specialists is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Therapeutic Rehab Specialists uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide. For example, Therapeutic Rehab Specialists may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Therapeutic Rehab Specialists may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, and for emergencies. We may provide de-identified information for research studies. We also provide information when required by law.

In any other situation, Therapeutic Rehab Specialist's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Therapeutic Rehab Specialists may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in a common area of our clinic. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances Therapeutic Rehab Specialists will consider all such requests on a case-by-case basis, but the Company is not legally required to accept them.

If you are concerned that Therapeutic rehab Specialists may have violated your privacy rights or if you disagree with any decisions that we have made regarding access or disclosure of your personal health information, please contact our HIPAA Compliance Officer at the address listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. For further information on Therapeutic Rehab Specialists' Health information practices, or if you have a complaint please contact the following office:

HIPAA Compliance Office
Therapeutic Rehab Specialists
6231 66th Street North
Pinellas Park, FL 33781

Patient Signature: _____ Date: _____