

FARMINGTON
SPORTS AND REHAB
CENTER

GENERAL PATIENT INFORMATION

Have you been treated by us before? Yes No

_____ _____ _____ Gender: M F
Last Name First Name Middle Initial

_____-_____-_____- ____/____/____- _____ _____
Social Security Number Date of Birth Age Occupation / Employer

_____ _____ _____ _____
Street Address City State Zip Code

(____) (____) (____)
Home Phone Cell Phone Work Phone

E-mail Address

_____-_____-_____- ____-____-_____- ____/____/____-
Spouse's Name or Parent / Guardian's Name (if under 18) Spouse's / Parent's S.S.N. Spouse's / Parent's D.O.B.

_____ _____ (____)
Emergency Contact Relationship to Patient Emergency Contact Phone Number

RESPONSIBLE PARTY FOR PAYMENT (INSURANCE CARDHOLDER INFORMATION)

Primary Insurance Company

_____ _____ _____ Gender: M F
Last Name First Name Middle Initial

_____-_____-_____- ____/____/____- _____ _____
Social Security Number Date of Birth Age Relationship to Patient

_____ _____ _____ _____
Street Address City State Zip Code

(____) _____ (____)
Home Phone Occupation / Employer Work Phone

MISCELLANEOUS INFORMATION

- What made you choose us for your therapy needs? _____
- What injury / symptoms brought you to therapy? _____
- What is the date of injury or recent onset of symptoms? ____/____/____-
- Is this a work related injury? Yes No If yes, has your employer been notified? Yes No
- Is this related to a motor vehicle accident? Yes No
- Have you retained an attorney regarding this injury? Yes No
- Do you have any drug allergies or other medical allergies? _____
- Do you have any special needs or requests? _____

HEALTH CARE PRIVACY NOTICE

With my consent, Farmington Sports and Rehab may use and disclose protected health information about me to carry out treatment, payment, healthcare operations. Please refer to Farmington Sports and Rehab's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practice prior to signing this consent. Farmington Sports and Rehab reserves the right to revise its Notice of Privacy Practices at any time. A revised notice of Privacy Practices may be obtained by forwarding a written request to **Farmington Sports and Rehabilitation Center, 602 Maple Valley Drive, Farmington, Missouri 63640.**

With my consent, Farmington Sports and Rehab may call my home or other designated location and leave a message on my voicemail or in person in reference to any item that assists the practice of carrying out my treatment, payment, and healthcare operations, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Farmington Sports and Rehab may mail to my home or other designated location any item that assists the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminder cards and patient statements as long as they are marked personal and confidential.

With my consent, Farmington Sports and Rehab may e-mail to my home or other designated location any item that assist the practice of carrying out treatment, payment, and healthcare operations, such as appointment reminder cards and patient statements. I have the right to request that Farmington Sports and Rehab restrict how it uses or discloses my protected healthcare information to carry out treatment, payment, and healthcare services. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Farmington Sports and Rehab use and disclosure of my protected health information to carry out treatment, payment, and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Farmington Sports and Rehab may decline to provide treatment to me.

INFORMED CONSENT FOR MEDICAL TREATMENT

I have been informed that Farmington Sports and Rehab is certified to provide outpatient rehabilitation services according to the plan of treatment established by my attending physician or the medical director of Farmington Sports and Rehab and the facility rehab team. I understand and accept treatment accordingly.

ASSIGNMENT OF BENEFITS

I hereby assign medical and / or surgical benefits, including major medical benefits to which I am entitled, private insurance, and any other health plans to **FARMINGTON SPORTS AND REHABILITATION CENTER**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am responsible for paying remaining charges that are not covered by said insurance company, if any. I hereby authorize said assignee to release all information necessary to secure payment.

MEDICARE BENEFICIARIES ONLY

I have been informed by Farmington Sports and Rehabilitation Center of the limits placed on Medicare Part B benefits for outpatient therapy services for 2008. I understand that provisions in the Medicare, Medicaid, and SCHIP Act of 2007 modified the existing therapy cap to allow patients to continue skilled therapy beyond the \$1,810 cap as long as the services are medically necessary and meet Medicare criteria for skilled therapy. The provision for an extension of the exceptions process for the therapy caps is only for six months. It ensures Medicare beneficiaries access to therapy services through June 30, 2008.

I hereby certify that the information given to me in applying for payment under the Title XVII and/or Title XIX of the Social Security Act is correct. I authorize the release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.

CANCELLATION POLICY

There is a \$45 charge for missed or cancelled appointments without 24 hours advanced notice. We have scheduled an agreed upon time especially for you which is now lost. We are unable to bill your insurance for this amount. We want to get maximum results from therapy and this means attending therapy on a regular basis. If you have more than three "no shows" you will be discharged from therapy.

FINANCIAL POLICY

We are committed to providing you the best possible care and at Farmington Sports and Rehab, we are pleased to discuss professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask the administrative staff if you have any questions about our fees, financial policy, or your responsibility.

- Payment is due at the time services are rendered.
- All co-insurances, co-payments, and deductibles are due as services are rendered.
- We will submit all billing to insurance companies as a courtesy for our clients; however, we will collect co-insurance charges, co-payments, and deductibles at the time of each visit.
- Verification of insurance benefits does not guarantee payment. I understand that I am responsible for all charges including those not covered by insurance and all collection costs including agency fees and attorney fees.
- All Workers' Compensation injuries must be verified and approved for eligibility by the facility administrative staff prior to receiving treatment. Approved Workers' Compensation cases will be excluded from payment at the time of service.
- Your insurance coverage is a contract between you and your insurance carrier. We will help to explain your benefits to you.
- If your insurance does not remit payment within 60 days, the balance will be due in full from you.
- Any money paid to you by your insurance company for services billed and rendered by Farmington Sports and Rehab or any of its associates shall be paid to Farmington Sports and Rehab immediately upon receipt. Failure to do so is illegal.
- I authorize payment of medical benefits from my insurance to **FARMINGTON SPORTS AND REHABILITATION CENTER** and release any medical information relating to all claims for benefits submitted on behalf of myself and / or dependents.
- By signing below, I understand my responsibilities as outlined in the above Financial Policy.

Your insurance deductible is \$ _____ per year. You have met \$ _____ of your deductible.

Your co-insurance amount is _____ / _____ per visit or approximately \$ _____ per visit.

Your co-payment is \$ _____ per visit.

Your insurance allows _____ visits per calendar year / per diagnosis. You have used _____ visits this year.

PATIENT CONSENT AND SIGNATURE

By my signature below I agree to abide by above policies and acknowledge that I have read, or have had read to me, and have received a photocopy upon my request of this document including the Health Care Privacy Notice, facility terms and conditions, financial policies (including Medicare policies if applicable), and Informed Consent and fully understand and have had all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original.

Print Name of Patient

Patient Signature (Parent / Guardian if patient is a minor)

_____/_____/_____
Date

Witness Signature

_____/_____/_____
Date

PAST MEDICAL HISTORY

Patient Name: _____

Date: _____

Are you presently working? Yes No

Date of next physician visit: _____

Date of injury / onset: _____

Have you had these symptoms before: Yes No

Check which apply to your symptoms:

- | | | |
|---|--|--|
| <input type="checkbox"/> Athletic / Recreational Injury | <input type="checkbox"/> Motor Vehicle Accident | <input type="checkbox"/> Injury related to a fall |
| <input type="checkbox"/> Work Related Injury | <input type="checkbox"/> Recurrence of Previous Injury | <input type="checkbox"/> Injury related to lifting |
| <input type="checkbox"/> Cause Unknown | <input type="checkbox"/> Other: _____ | |

Have you had surgery? Yes No If yes (please describe): _____

Do you have, or have you had, any of the following?

	Yes	No		Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Heat or Cold	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease / Attack	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Latex	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Other Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Heart Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain / Angina	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Metal Implants	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness / Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Are you Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Surgeries	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Skin Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Bowel / Bladder Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	Nausea / Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Urine Leakage	<input type="checkbox"/>	<input type="checkbox"/>	Ringling in your ears	<input type="checkbox"/>	<input type="checkbox"/>
Asthma / Breathing Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Liver / Gallbladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	Special Diet Guidelines	<input type="checkbox"/>	<input type="checkbox"/>
Smoking-related Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Stroke / CVA	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

Do you smoke? Yes No Frequency: _____

Do you drink alcohol? Yes No Frequency: _____

If yes on any of the above, please briefly explain and give approximate date:

Is there any other information regarding your past medical history that we should know about?

Four horizontal lines for writing past medical history information.

Are you currently taking any medications? Yes No Do you have any drug allergies? Yes No
If yes to either question above, please list medication(s) and why you are taking them as well as any allergies.

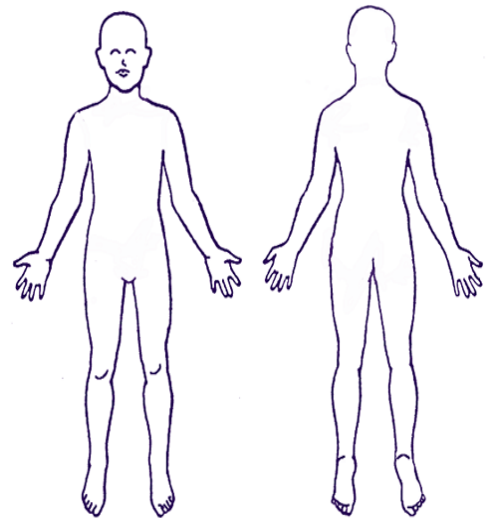
Five horizontal lines for listing medications and allergies.

Do you participate in any sports, exercise programs, or activities on regular basis? Yes No

The services of a social worker are available through Farmington Sports and Rehab.

Do you feel you are in need of these services? Yes No

If you are having pain, please rate the intensity of you pain on a scale of 1 to 10, with 0 being no pain and 10 being the worst pain possible: _____.



Please indicate location of symptoms:

- KEY:**
- ===== Numbness
- OOOO Pin & Needles
- XXXX Burning Pain
- //////// Stabbing Pain

Patient's Signature

____/____/____
Date

Parent / Guardian if patient is a minor

____/____/____
Date

I have reviewed the past medical history.

Therapist's Signature

____/____/____
Date