Comprehensive Rehabilitation

Patient's Name _____ Date of Birth _____

Mailing Address _____
STREET # OR P.O. BOX CITY STATE ZIP CODE

Home # (___) _____ Cellular # (___) _____Work # (___) _____

Email _____ _____ Add to eNewsletter List? Y N

Emergency Contact _____ Phone # (___) _____

Referring Physician _____Primary Care Physician _____

Appointment Reminder Preferred Method? ☐ Phone Call ☐ Text Message ☐ No reminders please

►HOW DID YOU HEAR ABOUT US?◄

☐ Doctor ☐ Past patient/ Friend ☐ Radio ☐ Newspaper ☐ Facebook/Social Media ☐ Website

► INSURANCE – FINANCIAL RESPONSIBILITY INFORMATION (required)◄

Person Financially Responsible _____ Phone _____

Address _____

Relationship to patient _____

Primary Insurance _____ _____ Group # _____

Subscriber's Name _____ ID # _____

Secondary Insurance _____ Group # _____

Subscriber's Name _____ ID # _____

► Workers Compensation Carrier ◄ _____ Claim # _____

MEDICARE and AMERIGROUP PATIENTS –Have you had any PT this year provided in your home or in another outpatient clinic? ☐ Yes ☐ No _____# of visits

Do you currently have Medicare home services? ☐ Yes ☐ No

IS THIS INJURY THE RESULT OF A WORK RELATED ACCIDENT ☐ YES ☐ NO
IS THIS INJURY THE RESULT OF AN AUTO RELATED ACCIDENT ☐ YES ☐ NO

WORKERS COMP/AUTO CLAIM ONLY PLEASE COMPLETE SECTION BELOW

Date of injury _____ Name of Insurance_____
Claim Number_____ Adjustor Name_____
Contact number _____

Has an Attorney Been Obtained ☐ **YES** ☐ **NO if YES,** Attorney Name _____

EMPLOYMENT INFORMATION (required) ☐ **Retired**

Employer _____ Phone _____
Address _____
Job Description _____ Are you a Student? ☐ **YES** ☐ **NO**

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MEDICATIONS LIST

Please fill out completely or provide us with a list of your Current Medications (prescribed and over the counter) as well as all Dietary Supplements including Vitamins, Herbs, Minerals

NAME	DOSE	NAME	DOSE

History of Present Problem

What is your injury/condition_____ Date of Injury/Onset _____

(If applicable) Type of Surgery/procedure _____ Date of Surgery _____

Please describe your physical limitations as a result of this injury/surgery _____

_____

On a scale of 0-10 (0 is no pain, 5 is moderate, 10 is severe (the worst pain imaginable))

At best: 0 1 2 3 4 5 6 7 8 9 10

At worst: 0 1 2 3 4 5 6 7 8 9 10

Presently: 0 1 2 3 4 5 6 7 8 9 10

Please mark the location of the pain on the diagram below.

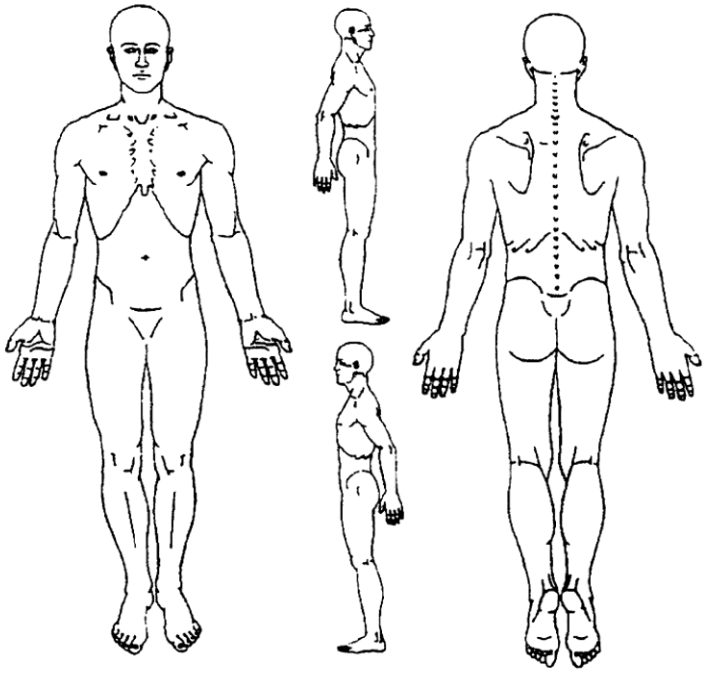
Problem **worsens** with:
Movement Inactivity Standing Lying Sitting
Other _____
_____

Problem **improves** with:
Movement Inactivity Standing Lying Sitting
Rest Medication Heat Ice
Other _____

How frequently are you bothered by this problem?
Constant Occasional/Variable
Other _____

How would you describe the problem?
Dull/Achy Sharp Burning Tingling
Other _____

Do you have any other symptoms?
Yes No If yes, Please explain _____
_____



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(615) 666-5095 • Fax (615) 802-6194 • www.comprehab.net

Comprehensive Rehabilitation

MEDICAL HISTORY Please check any medical conditions that we should be aware of

	Allergies		Diabetes Type 1		Kidney Problems
	Alzheimer's		Diabetes Type 2		Lupus
	Anemia		Emphysema/Chronic Bronchitis		Metal Implants or Pins
	Anxiety		Fibromyalgia/Chronic Fatigue		Multiple Sclerosis
	Asthma		Fractures		Osteoarthritis
	Bladder/Bowel Problems		Gastrointestinal Problems		Osteoporosis/Osteopenia
	Cancer		Headache/Migraines		Pain Syndromes/CRP
	Cardiac Disease/ Heart Attack		Hepatitis		Parkinson's Disease
	Cardiac Pacemaker/ Defibrillator		Hernia		Rheumatoid Arthritis
	Circulation Problems		High Blood Pressure		Seizures
	Concussion/Head Injury		Huntington's		Stenosis (lumbar or cervical)
	Current Infection		Immunosuppression		Stroke
	Degenerative Disc Disease		Incontinence		Thyroid Problems
	Depression		Joint Replacement		Vision Problems

Please Provide further information on any diagnosis checked_____

_____

Have you suffered from any illness not listed? _____

_____

What are your goals for physical therapy? _____

_____

FOR WOMEN ONLY

	Caesarean Deliveries		Endometriosis		Stress Incontinence
	Complicated Pregnancies		Hysterectomy		Vaginal Deliveries
	Currently Pregnant		Pelvic Inflammatory Disease		

Have you received medical or rehabilitative care for this injury? Check all that apply

	Chiropractor		Massage Therapist		CT Scan
	General Practitioner		Pain Management		EMG or Nerve Test
	Ob/Gyn Practitioner		Physical Therapy		MRI
	Orthopedist		Occupational Therapy		X-ray
	Neurologist				Joint or Spine Injections

Please list any surgical procedures by type and date

Type _____ Date _____

Type _____ Date _____

Type _____ Date _____

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Authorization & Guarantee

AUTHORIZATION TO RELEASE / OBTAIN INFORMATION

I hereby authorize the release of any information, including reports of diagnosis, treatment prognosis, treatment recommendation, benefits payable, as well as any other data pertinent to my treatment to the physician who referred me for therapy, as well as any organization responsible for payment of my account. I also authorize my referring physician to release to Comprehensive Rehabilitation any and all medical or other information pertinent to my treatment.

MEDICARE

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I ok any holder of medical or other information about me, to release to the Social Security Administration or its intermediaries or carriers any such information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductibles and co-insurances.

GUARANTEE OF PAYMENT

In consideration of the services rendered to me by Comprehensive Rehabilitation I hereby guarantee payment for any and all services rendered to which are not covered or allowable by my insurance, together with collection costs, including reasonable attorney's fees. I also understand that all bills are due and payable upon presentation.

RETURNED CHECKS

We are happy to accept your personal check, however there will be a $25.00 fee for any check returned to non-payment to comprehensive Rehabilitation.

PRIVATE INSURANCE

I understand that as a courtesy, Comprehensive Rehabilitation will bill my insurers/private insurance for my treatment/visits rendered. Should there be any changes in my insurance coverage during the course of physical therapy, I will provide Comprehensive Rehabilitation with the new information. Failure of notification can result in possible denial of claim. In the event that payment is not received for any reason, you will be responsible for the full balance.

INSURANCE PRE-AUTHORIZATION

As a courtesy, Comprehensive Rehabilitation will make every effort to contact your insurance carrier and attempt to make a determination as to your insurance coverage, however any such determination of coverage is no guarantee of actual coverage or insurance payment for services rendered. We encourage you to contact your insurance company for any benefit information.

SUPERVISION OF CHILDREN

I understand that this facility is not an appropriate setting for children due to safety reasons for the children, myself and other patients. Any Children allowed in the treatment areas may NOT play on the equipment or move around the treatment area without supervision. We ask that when possible please arrange for alternative childcare when attending sessions.

ASSIGNMENT OF BENEFITS

I authorize that the payment of authorized benefits to be made directly to Comprehensive Rehabilitation for any services that are reimbursed by Medicare, TennCare, and any other responsible payor sources.

CONSENT FOR TREATMENT

I hereby consent to such treatment procedures and patient care which, in the judgement of my therapist and or physician, may be considered necessary of available while a patient at Comprehensive Rehabilitation.

Signature of Patient/Insured/Patient Representative **Date**

Witness by

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice of Privacy Practices for Protected Health Information Health Insurance Portability & Accountability Act of 1996 (HIPAA)

Due to increased awareness of the need for more strict guidelines regarding privacy of your protected health information, the Health Insurance Portability & Accountability Act of 1996 (HIPAA) was legislated, effective April 14, 2003. As part of this law, Comprehensive Rehabilitation, Inc. is required to provide you with the option of receiving a copy of this Notice.

Please Select One:

☐ **Waiver** I, the undersigned, am aware of my right to receive a paper copy of the above Notice and have declined such Notice.

OR

☐ **Acknowledgement (Receive HIPAA Paper Copy)** I, the undersigned, acknowledge with my signature that I have received a paper copy of the above mentioned Notice. I understand that it is my responsibility to read and be aware of these rights as outlined in the Notice.

_____

Please print name (Minor's name if applicable)

_____

Signature of Patient/Insured/Patient Representative **Date**

I authorize contact using my home/mobile/cell phone number for discussing treatment, confirming appointments, leaving messages and resolution of the balance of my account.
_____(initial)

I authorize contact using my email address for discussing treatment, confirming appointments, leaving messages and resolution of the balance of my account.
_____(initial)

I hereby agree and give my consent for Comprehensive Rehabilitation, Inc. to furnish physical therapy care and treatment in the gym environment.
_____(initial)

Payment Policy

CO-PAY / CO-INSURANCE
I, the undersigned, certify that I (or my dependent) have insurance with the named insurance on the patient registration form and assign directly to Comprehensive Rehabilitation all insurance benefits, if any, otherwise payable to me for services rendered

Co-payments are due at every session and not considered billable. This is a contractual agreement between you and your insurance company.

If you still have a outstanding deductible, a $_____ payment will be collected at each visit until your deductible has been met by cash, check, or credit card at the time services are rendered. We will send your claim to your insurance carrier and will bill you for any additional patient responsibility, if any, which is determined by your carrier.

If your insurance carries a co-insurance, a $_____ payment will be collected at each visit. This amount may not cover the total amount due for each visit; this amount is taken to offset the final balance and will be credited toward you total responsibility. Once Comprehensive Rehabilitation received notice (EOB) and payment from your insurance carrier for all claims submitted and processed, you will either receive a bill from Comprehensive Rehabilitation for additional unpaid balance, or a reimbursement check for any over payment.

If you choose to pay cash for your services, you will pay $125 for the initial evaluation and $25 for each additional 15 minute increment up to one hour. Payment will be collected at each visit by cash, check or credit card. If extenuating circumstances should arise, you can discuss a payment plan with our Administrator.

If we are contracted with your insurance company, we must follow our contract and their requirements. It is the insurance company that makes the final determination of your coverage eligibility.

By signing below, you acknowledge that you have **read, understand, and agree** to all the policies listed above.

_____

Signature Patient/Insured/Patient Representative **Date**

_____

Print Name

_____

Relationship to Patient

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GENERAL INFORMATION

Thank you for choosing Comprehensive Rehabilitation for your physical therapy needs. We are happy to assist you with your recovery. Physical therapy services require your consistent attendance in order to meet the goals expected by your referring physician, your therapist and most importantly, YOU!! We will do our best to schedule your therapy appointments at times that are most convenient for you. Please discuss your scheduling limitations with your therapist and the scheduler. Comprehensive Rehabilitation will provide you with a printed schedule weekly as well as reminder calls/texts.

Please read the statements below and initial them to indicate your understanding.

_____ *I understand that I am required to arrive **on time** for my scheduled appointments. If I am less than 15 minutes late and have contacted Comprehensive Rehabilitation, Inc. to notify that I will be late, I may complete the remaining time scheduled for my session, **knowing that I will not receive a full session**. If I am more than 15 minutes late and have not contacted Comprehensive Rehabilitation, Inc., they hold the right to consider my appointment a "No-Show."*

_____ *I understand that I if I can not make it to my scheduled therapy appointment **I am required to contact Comprehensive Rehabilitation by phone at 615-666-5095 to reschedule my appointment for another day within the same week.***

_____ *I understand that I if I do **not show up for or if I cancel a total of 3 visits over a two week time period I will be discharged from therapy.***

_____ *I understand Comprehensive Rehabilitation **may contact me via phone and leave a detailed message or text.***

_____ *I understand If I should choose to suspend or terminate my care and treatment, **I will need to contact the front office staff to make notification** and I will be discharged. Comprehensive Rehabilitation will inform my physician my physical therapy services being discontinued per myrequest.*

Signature Patient/Insured/Patient Representative **Date**

Comprehensive Rehabilitation

Dear Patient,

Thank you for choosing Comprehensive Rehabilitation for your physical therapy needs! As a health care service provider, we realize that you DO have a choice for your care – and we are honored that you have chosen us!

To prepare for your first visit and initial evaluation, we would like to provide you with some information and helpful hints. The healthcare system can be challenging to navigate – and we hope that this helps to take some of the guesswork out of the process.

What should I wear to my appointments?
We recommend that you wear comfortable clothing. If we will be addressing issues with a particular body part such as your knee or shoulder, it would be helpful to wear clothing that allows "easy access" to the region. Part of your evaluation may include "palpation" or touching the injured area.

Can I have someone accompany me for the initial evaluation?
We understand that medical appointments can sometimes be overwhelming and having a friend or family member who knows you well can be helpful. We will do our best to accommodate any such request.

Can I have someone accompany me for my treatment sessions?
We would ask that you limit your visitors to one. In doing so, the privacy of other patients and the safety of our patients and staff is guaranteed.

Will my insurance cover the cost of my therapy?
There are many insurance and even more insurance policies out there with different levels of coverage. Our front office staff will ask for your insurance card(s). Your insurance card will be copied, and we will all your insurance company on your behalf to verify you benefit eligibility and any out-of-pocket costs to you. It is important that you present ALL insurance information on the first day.

What if I cannot afford the out-of-pocket costs associated with my insurance plan?
Providing you the care that you need so that you can get back to doing what you want is important to us! Comprehensive Rehabilitation is always willing to assist our patients with the financial burden associated with co-payments, deductibles, and co-insurance costs. If cost of care is a concern, please do not hesitate to mention it to our front office staff or your therapist. They will initiate the process to get you in contact with our business office to establish a payment plan.

Do I need to complete all of the paperwork?
YES!! Most of the necessary paperwork is attached here. It is important that you complete all of it to the best of your ability. If there is something you do not understand, simply leave it blank and we can review it with you during your first visit. Just come 10-15 minutes before your scheduled appointment time to allow our staff time to help you complete it before your evaluation begins. If you maintain a separate copy of your medical history and/or medication list, you may present them with this paperwork (in place of writing it out) an we can make a copy for your patient chart.

Should I bring any test results to my appointment?
Very often, patients have undergone tests that are pertinent to their reason for a referral to physical therapy. These may include tests such as X-ray, EMG, CT scan or MRI. If you have had testing relevant to your diagnosis, please bring a copy of your test results to your first appointment.

How often will I have an appointment?
Your therapist will complete an initial evaluation on your first visit. At the end of that visit, the therapist will discuss with you their findings and thoughts about appropriate interventions, which includes the frequency and duration of your treatment. Typically, patients are seen 2-3x/week for a period of 6-8 weeks. This varies upon your diagnosis and complexity of your problem(s).

How long are the appointments?
Initial visits are usually 30 minutes to 1 hour. After that visits typically last 45 minutes to an hour, depending on the condition we are seeing you for and how much time your therapist determines is needed to provide the best care for you. No two patients are ever the same!

Is there anything else I need to know?
We are excited to have you come in to see us! We do our best to create a fun atmosphere that helps you heal and feel supported while doing so. Please know that we are here for YOU! Never hesitate to reach our to any of our staff members with an issue or concern!

We are looking forward to meeting you and getting you started on the road to recovery!

Sincerely,
The Comprehensive Rehabilitation Team

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