

107 Cleveland Avenue

Cocoa Beach, FL 32931

Phone: (321) 799-0030

**PATIENT INFORMATION**

Name Middle Initial

Street Address

City State ZIP

Home Phone Cell Phone Email

Date of Birth Age Sex ­­­­­­­­­­­­­­­­­

SS# (If covered by the VA please provide your social) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Phone

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Family Doctor/Internist

**Patient HIPAA Consent Form**

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

* Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
* Obtaining payment from third party payers (e.g. my insurance company);
* The day-to-day healthcare operation of your practice.

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

**I give permission to share appointment, billing, or medical information with the person(s) named here:**

First & Last Name Association

* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Responsible Party Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PATIENT MEDICAL HISTORY**

Name (Printed): \_\_\_ Referring Physician: \_\_\_\_\_\_

**AUTO/LAWSUIT**: Date of Injury: \_\_\_\_\_\_\_ Is an attorney involved in this case? YES NO

Have you had surgery for this injury? YES NO Number of surgeries: 1 2 3 4

Type of surgery: Date:

Please enter your approximate: HEIGHT WEIGHT

Are you currently taking any prescriptions or non-prescription medications? YES NO

|  |  |  |
| --- | --- | --- |
|  |  | List Medications |
| [ ] | Anti-inflammatories |  |
| [ ] | Muscle Relaxes |  |
| [ ] | Pain Medications |  |

Have you had any medical or rehabilitative services for this injury/episode? (Imaging, Chiropractic care, Therapy, etc..)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you now have or have you ever had ANY of the following?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | YES | NO |  | YES | NO |
| Asthma, bronchitis, or emphysema | \_\_\_ | \_\_\_ | Severe/frequent headaches | \_\_\_ | \_\_\_ |
| Shortness of breath/chest pain | \_\_\_ | \_\_\_ | Vision/hearing difficulties | \_\_\_ | \_\_\_ |
| Coronary heart disease or angina | \_\_\_ | \_\_\_ | Dizziness or Fainting | \_\_\_ | \_\_\_ |
| Heart attack or surgery | \_\_\_ | \_\_\_ | Weight loss/Energy Loss | \_\_\_ | \_\_\_ |
| Do you have a pacemaker? | \_\_\_ | \_\_\_ | Hernia | \_\_\_ | \_\_\_ |
| High blood pressure | \_\_\_ | \_\_\_ | Allergies | \_\_\_ | \_\_\_ |
| Stroke/ITA | \_\_\_ | \_\_\_ | Any joint/muscle pain | \_\_\_ | \_\_\_ |
| Blood clot/emboli | \_\_\_ | \_\_\_ | Joint Replacement | \_\_\_ | \_\_\_ |
| Epilepsy/seizures | \_\_\_ | \_\_\_ | Shoulder injury/surgery | \_\_\_ | \_\_\_ |
| Anemia | \_\_\_ | \_\_\_ | Elbow/hand injury/surgery | \_\_\_ | \_\_\_ |
| Infectious disease | \_\_\_ | \_\_\_ | Neck/back injury/surgery | \_\_\_ | \_\_\_ |
| Diabetes | \_\_\_ | \_\_\_ | Knee injury/surgery | \_\_\_ | \_\_\_ |
| Cancer or chemotherapy/radiation | \_\_\_ | \_\_\_ | Leg/ankle injury/surgery | \_\_\_ | \_\_\_ |
| Arthritis/swollen joints | \_\_\_ | \_\_\_ | Are you pregnant? | \_\_\_ | \_\_\_ |
| Osteoporosis | \_\_\_ | \_\_\_ | Do you smoke? | \_\_\_ | \_\_\_ |
| Sleeping problems/difficulties | \_\_\_ | \_\_\_ | Difficulty/Frequent urinating | \_\_\_ | \_\_\_ |
| Thyroid Condition | \_\_\_ | \_\_\_ | Night Pain | \_\_\_ | \_\_\_ |

List any other information that would assist us in your care:

Patient or Responsible Party Signature: Date:

*I have reviewed this information with the patient.*

THERAPIST (Printed) Michael Nichols, DPT THERAPIST (Signature)

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**Consent for Care and Treatment**

I, the undersigned, do hereby agree and give my consent for In Balance Rehab to furnish the medical care and treatment considered necessary and proper in assessing or treating (Print Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_’s physical and mental condition.

Patient or Responsible Party Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Benefit Assignment/Release of Information**

I hereby assign all medical benefits to include major medical benefits to which I am entitle, including that from Medicare, Medicaid, private insurance and third part payers to In Balance Rehab. A photocopy of this assignment is to be considered as valid as the original. I hereby authorized said assignee to release all information necessary, including Medical Records, to secure payment.

Patient or Responsible Party Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Financial Policy Statement**

In Balance Rehab will bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your insurance company establishes an internal *usual and customary fee schedule*, you will be responsible for the difference remaining.

If your insurance company makes any payments directly to you for services rendered by us, you recognize an obligation to promptly remit same to In Balance Rehab.

The above does not apply for those claims considered under Worker’s Compensation. However, be advised that if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the usual amount of charges for services rendered to you.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed to In Balance Rehab, including court costs, collection agency fees and attorney fees.

**Estimated Insurance Benefits**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Estimated Patient Payment**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Note:** Estimated coverage information is provided as a courtesy to our patients, but is not intended to release them from total responsibility for their account balance.

The above information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Patient/Guardian/Responsible Party signature |  | Date |
|  |  |  |
|  |  |  |
| In Balance Rehab Representative/Witness |  | Date |

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**New Patient Orientation**

1. Are you okay with us contacting you through the following methods?
	* 1. Phone Calls YES NO
		2. Email: YES NO
		3. Text Messages: YES NO
2. Reserve your appointments well in advance to ensure availability.
3. Be on time for your appointment. If you are more than 15 minutes late from the scheduled time, you may be required to reschedule for another day.
4. Give us 24-hours notice when canceling your appointment. Since appointment slots fill up fast, we require a 24-hour notice when canceling your appointment. If you fail to show for your appointment without calling, you will personally be charged $25.00 a visit.
5. All insurance plans are different. We will call your insurance carrier to verify your benefits, but it is ultimately your responsibility to know your insurance plan benefits.
6. All co-pays, co-insurance and payments for our services will be billed to you and are due prior to continuing treatment. It is unlawful to routinely waive co-payments, deductibles, co-insurance or other patient responsibility payments.
7. Payment methods available for your convenience include: personal checks, credit cards or cash.

I have carefully read and fully understand the policies described above. I herby agree to follow these polices to the best of my ability.

 New Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_