COMPLETE CARE PHYSICAL THERAPY

PATIENT INFORMATION : Please Print

Patient Name_____ Home Phone_____

Address_____ Cell Phone_____

City_____ State_____ Zip_____

Date of Birth_____ Male___ Female___ SS#: _____

Email:_____ Marital Status: Single__ Married__ Divorced__ Widowed___

Patient Employer_____ Work Phone_____ Job_____

PARENT OF GUARDIAN / RESPONSIBLE PARTY INFORMATION

Name_____ Home Phone_____

Relationship to patient:_____

Signature of Parent/ or Responsible party:_____

Date:_____

HEALTH INSURANCE INFORMATION- PRIMARY

Insurance Company Name_____Suscriber:_____DOB:_____

HEALTH INSURANCE INFORMATION- SECONDARY

Insurance Company Name_____Suscriber:_____DOB:_____

Patient information Referring Physician_____ Date of Next Appointment _____

Primary Care Physician_____

SYMPTOM/TREATMENT INFORMATION

Diagnosis or Area of Symptoms_____ Date of Injury or Onset_____

Have you received any chiropractic, physical, occupational or speech therapy for this condition yet this year? __ Yes

How many visits?___ Where?:_____

Have you had/are you having HOME HEALTH CARE? When_____ How many_____

ACCIDENT: Are your symptoms related to an accident? Yes_____ Date of Accident: _____

Who is to be billed for PT services:___Private Insurance _____Auto Insurance _____Third Party

Attorney (if applicable):_____Phone#:_____

WORKER'S COMPENSATION (Employment Related Injury)

BWC Claim #_____Injury Date_____ Employer at the time of Injury_____

EMERGENCY CONTACT: Name:_____ Phone #_____

Emergency Address_____

City State Zip

Relationship to Patient_____

Patient Signature:_____ **Date**_____

(Parent or guardian if patient is a minor)

Staff Initials_____

Complete Care – Perrysburg

27511 Holiday Lane, Suite 105
Perrysburg, OH 43551

Ph: 419.873.3488
Fax: 419.873.4777

Complete Care – West

3130 Central Park West, Suite C
Toledo, OH 43617

Ph: 419.720.1290
Fax: 419.720.1291

Complete Care at Holiday Park
www.completecarephysicalrehab.com

Medical History Form

Dear Patient,
Please take a moment to complete the questions below. Depending on your answers, we may modify our treatment procedures for their effectiveness and for your safety.

Your present: Height_____ Weight_____

Do you have now, or have you ever had any of the following:

Cancer	Yes___ No___	**Metal Implants**	Yes___ No___
Diabetes	Yes___ No___	**Respiratory Problems**	Yes___ No___
Epilepsy or Seizures	Yes___ No___	**Osteopenia**	Yes___ No___
Heart Disease	Yes___ No___	**Osteoporosis**	Yes___ No___
Pace Maker	Yes___ No___	**High blood Pressure**	Yes___ No___

Surgeries Yes___ No___If yes, please explain _____

Allergies Yes___ No___If yes, please explain_____

Chronic Conditions Yes___ No___If yes, please explain_____

Medications_____

Are you pregnant now? Yes___ No___
Are you a smoker? Yes___ No___

_____ _____
Patient Signature Date

_____ _____
Therapist Signature Date

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NOTICE OF PRIVACY PRACTICES

Our practice is committed to maintaining the privacy of your protected health information, while providing quality medical care. In accordance with the Health Insurance Portability & Accountability Act (HIPPA), we provide you with the Privacy Practices (the Notice), which describes how we may and may not use and disclose your protected health information.

Uses and Disclosures of Your Health Information

We may use and disclose your health information to others without your authorization to individuals or groups directly related to your care. This must take place to treat you at this facility. This includes transfer of information in order to:

- communicate with referring physician
- get paid for services we provide to you
- run our medical practice
- remind you of appointments
- Workers' Compensation requests

Other Uses and Disclosures of Your Health Information

We may also disclose your health information to others not directly involved with your care, on rare occasions without your authorization for:

- health and safety reasons
- military purposes
- law enforcement requests
- national security reasons
- corner, medical examiner or funeral director use

All Other Uses and Disclosures of Your Health Information

All other uses or disclosures of your protected health information, outside of those listed in the Notice, will only be made with written authorization and may include fee for copying services. This would include, but not limited to:

- lawsuits or legal action
- personal records

Your Rights Regarding Your Health Information

Subject to the terms and conditions described in the Notice, you have a number of rights under state and federal law. They include your right to:

- get a copy of your medical record
- apply to change your medical record if you think it's wrong
- get a list of parties with whom we have shared your health information
- ask us to limit the information we share
- ask for a copy of our privacy notice
- write a letter of complaint to your medical practice or the federal government if you believe your privacy rights have been violated
- **Our Obligations Regarding Your Health Information**

We are required by federal law to:

- maintain the privacy of your health information
- provide you with this Notice
- comply with the terms of the Notice, as currently in effect

Questions, complaints, and any special privacy issues should be directed to our office manager. She will direct your concern appropriately.

COMPLETE CARE PHYSICAL REHABILITATION

- I have received, or been offered a copy of the "Notice of Privacy Practices"

  Patient Name (Please Print): _____ Date: _____

  Patient Signature: _____

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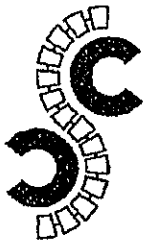

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Authorization for treatment, Acknowledgement of Financial Responsibility and Assignment of Benefits

I acknowledge that I am legally responsible for all charges in connection with the medical care, treatment and therapy provided by representatives and personnel of Holiday Park Physical Rehabilitation. I consent to the release of any medical information, including diagnosis and the records of any treatment or examination rendered to me for such services to third party payers, health care practitioners and/or managed care organizations. I hereby assign, authorize and direct payment of my medical benefits to Holiday Park Physical Rehabilitation. I understand Complete Care Physical Therapy will assist me in submitting my claims to my insurance carrier. I understand my insurance carrier may not approve or reimburse my medical services in full due to benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, policy deductibles and co-insurance except where my liability is limited by contact or State or Federal law. Furthermore, any information given to us may be used for the collection for payments for services provided.

☐ **I understand there may be $25 charge if I do not cancel prior to any scheduled appointments.**

*** Your evaluating therapist will explain the medical necessity for use of the following:

☐ **I understand that use of decompression machines (computerized traction) may not be a covered charge by my insurance carrier. I acknowledge that I am financially responsible for a $25 charge per use of this service, if applicable.**

_____ _____
Signature of Patient or Guardian Date

_____ _____
Printed name of Patient or Guardian Date

_____ _____
Staff Signature Date

How did you happen to choose Complete Care Physical Rehab for your physical therapy?
Check all that apply:

_____my primary care physician sent me

_____my surgeon sent me

_____a friend/family member

_____I saw your website

_____I was a patient here before

_____it's closed to work/home/school

_____I know someone who works here

_____I saw your ad on television

_____my pain management doctor sent me

_____I got a pamphlet at my doctor's office

_____I saw your ad in the phone book

_____I contacted my insurance company

_____I found you on my ins. company website

____other: Please explain_____

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Patient Payment Agreement

At Complete Care Physical Therapy it is our concern to assist you with your Physical Therapy needs. To ensure open communication regarding the expense incurred regarding your care, see below:

1. The cost of all care rendered to you by Complete Care Physical Therapy is your responsibility. Ultimately you are responsible for all services rendered.
2. Complete Care Physical Therapy requests a **confirmed pay source** at the time of the Initial Evaluation. A pay source makes payment at the time of billing each service. If a pay source is not determined, the patient becomes "self-pay" and responsible for all cost at the time of treatment.
3. Complete Care Physical Therapy **does not** accept assignment regarding any attorney involvement in Personal Injury cases. We will supply any requested information to assured sources after the patient has signed an authorized Records Requests, and payment of costs relating these services are received . (See Record Request Fee Schedule)
4. Complete Care Physical Therapy **does** accept assignment for all insurances and/or paying entities.
5. If payment of services is not received in a timely manner, an interest charge can be applied by Complete Care Physical Therapy.

_____ _____

Patient Signature (or parent/authorized Representative) DATE

_____

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When proper information requested is not received, ***(Drivers license, Insurance cards, Workers Compensation information, C9's, etc.)*** in the time we need, this makes it difficult for payments to be processed for our patient's bills.

Due to not receiving the information needed to process the bills, patients are held responsible for those dates of service balances unless information is received.

I, _____, understand the above statement regarding insurance information/payment information on my account.

_____ _____

Patient Name Date

_____

CC Initials