



3210 Jenks Avenue
Panama City, FL 32405
850-763-0603

12125 PCB Parkway
Panama City Beach, FL 32407
850-236-7497

PATIENT INFORMATION

Name _____ Social Security# _____

Address _____ Email Address _____

City _____ State _____ Zip _____ Home Phone _____ Cell Phone _____

Sex M F Age _____ Date of Birth _____ Single Married Divorced Widowed

Whom may we thank for referring you? _____ Date of Onset/Injury: _____

Where you hurt on the job? _____ Is this injury a result of a car accident? _____ Date of car accident _____

In case of emergency who should be notified? _____ Phone # _____

EMPLOYMENT INFORMATION

Patient Employed By _____ Occupation _____

Business Address _____

Phone _____ Are you currently off work due to your injury? _____

Present Employment Full Time Part time

GENERAL MEDICAL INFORMATION

Physician Name _____ Date of Surgery _____ Date returned to work _____

Have you sought previous treatment for this injury? _____ Are you receiving treatment at this time? _____

Please list any MEDICATIONS that you are currently taking: _____

Please check the following conditions that apply:

- | | | |
|--|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Dizziness or Fainting | <input type="checkbox"/> Emotional Problems |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Chest Pain/Heart Attack | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Surgery/Date | <input type="checkbox"/> Psychological Problems | <input type="checkbox"/> Other (Specify Below) |

Do you have specific expectations and goals for your therapy program? _____

Is an Attorney involved in you case? Yes No If yes, please give the following information:

Name of Attorney: _____

Address of Attorney: _____



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Consent for Care and Treatment

I, the undersigned, do agree and give my consent for *Therapy One Rehabilitation Center, Inc.*, to furnish medical care and treatment to myself and/or my minor child _____; and that the service is considered necessary and proper in diagnosing and treating my physical and/or mental condition. I authorize said assignee to obtain information necessary for treatment.

Patient/Guardian:

Date

Benefit Assignment/Release of Information

I, assign all medical and/or surgical benefits including Major Medical, Medicare, Private Insurance Carrier(s), and any other health plan coverage to which I am entitled to *Therapy One Rehabilitation Center, Inc.*, to receive payment for their services. A photo copy/facsimile of this assignment is to be considered as valid as the original. I, authorize *Therapy One* to release all information necessary, including Medical Records, to secure such payment.

Patient/Guardian:

Date

Financial Policy Statement

Although you are responsible for the entire bill when services are rendered, as a courtesy to you, it is our policy to bill your insurance carrier for payment. We require that arrangements for payment of you deductible and 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. If your insurance carrier in excess of the balance of your account subsequently makes any payment, we will promptly refund any overpayment due you. If any payment is made directly to you for services billed by us, you must recognize your obligation to promptly remit it to *Therapy One Rehabilitation Center, Inc.*

The above does not apply for those patients that are considered by Workers' Compensation. However, be advised as a Compensation patient, you will be held responsible for all charges in the event your claim is controverted.

I understand *Therapy One Rehabilitation Center, Inc.*, may turn my account over for collection and I will be responsible for all costs of collection monies owed, including court costs, collection and attorney fees. I further understand that if I fail to make any of the payments for which I am responsible in a timely manner, I will be charged a 1.5% service charge monthly on the remaining balance.

I understand my responsibility for the payment of my account. I also understand any estimated coverage information is provided as a courtesy and is not intended to release me from the responsibility of my account.

Patient/Guardian:

Date

Acknowledgement of Receipt of Notice of Privacy Practices

Therapy One Rehabilitation Center reserves the right to modify the privacy practices outlined in the notice.
I have received a copy of the Notice of Privacy Practices for Therapy One Rehabilitation Center.

Patient/Guardian:

Date

Signature of Patient Representative (Relationship to patient)

Date



MEDICARE QUESTIONNAIRE

This questionnaire is for Medicare patients only. It will help us determine if you qualify for coverage under the Medicare program. It is the responsibility of your evaluating therapist to determine your coverage. If it is determined that services are non-covered, you will be asked to pay for these services at the time they are rendered. Please complete the following questions completely and concisely. Thank you.

-
1. Do you have a physician signed prescription? Yes No
 2. Have you received Home Health Care within the last 6 months? Yes No
 3. Briefly describe your significant medical history (relative to this injury/illness).

 4. What is the date of onset? ___/___/___ If this is a chronic condition, indicate the most recent date that you experienced a “flare up”. (Medicare does require an exact date).
 5. How did the “flare up” occur or what were you doing when you noticed the increase in pain?

 6. What are your current medical findings (i.e.: x-ray results, MRI findings, etc.):

 7. Are you aware of your diagnosis and prognosis? Please describe:

 8. Summarize any previous rehabilitation treatment you have received for this injury, and the time frame in which you were treated. (i.e.: physical, occupational, massage therapy; chiropractic treatment, etc.)

 9. Describe how this injury/illness interferes with your daily living activities or your ability to carry out and perform tasks required in your daily life. (i.e.: unable to lift arms to comb your hair, unable to stand in the shower without assistance, unable to bend down to socks and shoes, etc.) _____

Patient Signature

Date



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IMPORTANT:

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

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, initial evaluations and daily treatment received will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from all sources of coverage such as private insurance carriers, automobile insurer of credit card companies that you may use to pay for services. For example, your insurance carrier may request and receive information on dates of service, services provided, and the medical condition being treated.

Health care operations: Your health information may be used as necessary to support the day-to-day activities and management of *Therapy One Rehabilitation Center, Inc.* For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Disclosures Requiring your Authorization: Disclosure of your health information or its use for any purpose other than those listed above require your specific written authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Appointment reminders: Your health information may be used by our staff to call for appointment reminders.

Information about treatments: Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Marketing: Your name will not be used for marketing efforts without your written permission.

YOUR PATIENT RIGHTS

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice. (This is our printed notice)

THERAPY ONE REHABILITATION CENTER DUTIES

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies that are outlined in this notice.

RIGHT TO REVISE PRIVACY PRACTICES

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

REQUEST TO INSPECT PROTECTED HEALTH INFORMATION

As permitted by federal regulations, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting *Therapy One's Patient Coordinator or Privacy Official/President*. Your request will be reviewed and generally be approved unless there are legal or medical reasons to deny the request.

PRIVACY COMPLAINTS

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Official/President
Therapy One Rehabilitation Center
3210 Jenks Avenue
Panama City, Florida 32405

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.