THERAPY ONE
Rehabilitation, Health & Fitness Center
The personalized care you need to feel better fast.

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

13405 PCB Pkwy, Suite A
Panama City Beach, FL 32407
850-236-7497

PATIENT INFORMATION

Preferred Name_____ AGE____

Name _____ Social Security # _____

Address _____ Email Address _____

City _____ State ____ Zip _____ Home Ph _____ Cell Ph _____

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

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

Were 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:

_____ High or Low blood Pressure
_____ COPD/Asthma
_____ Cancer
_____ Headaches
_____ Epilepsy/Seizures
_____ Heart Surgery/Date
_____ Pacemaker
_____ MRSA (Methicillin Resistant Staphylococcus Aureus)
_____ Sleeping Problems
_____ Osteoporosis
_____ Dizziness or Fainting
_____ Diabetes Type 1 or 2
_____ Chest pain/Heart Disease
_____ Psychological Problems
_____ Kidney Problems
_____ Abnormal Bowel/Bladder
_____ Arthritis
_____ Fractures
_____ Emotional Problems
_____ Allergies
_____ Stroke
_____ Hepatitis/HIV
_____ Gout
_____ Other (Specify below)

_____

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

Name & Address _____

Have you had home health in the past 6 months? Yes or No If yes, where_____

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

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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

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Authorization for Release of information

Patients Name: _____

Date of Birth: _____ Social Security: _____

I hereby authorize THERAPY1ONE Rehabilitation Center & its duly authorized agents & employees to release/obtain information concerning my illness & treatment to the person/parties listed below.

Person/Company you would like your information released to including, but not limited to scheduled appointment times, progress of your treatment, and amount of visits you have attended, and medical records.

- _____
- _____
- _____

The question of privacy between your institution, my attending physician or physicians & myself is waved. I do not authorize release of any other third party. I understand that THERAPY1ONE Center & its staff, employees, officers, & directors cannot be responsible for confidentiality of information disclosed after said information has been released pursuant to this authorization & hereby release them from any liability arising from said disclosure.

I may revoke this authorization at any time, and that upon fulfillment of the above stated purpose of the lapse of 12 months from date of signature, whichever comes first, this consent will automatically expire without my express revocation.

Signature of Patient_____
Witness_____ Relationship_____

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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.

Patient Referral Questionnaire:

How did you hear about us? (Please check one)

_____ **Doctor** (Please provide name of referring doctor) _____

Did the doctor **specifically** refer you to THERAPY1ONE? (Y/N)_____

_____ **Past Patient**

_____ **Referred by Family member/Friend/Past patient**

(Please provide name of person who referred you) _____

_____ **Billboard/Digital sign**

_____ **Google/Other search engine/Website/Social Media**

_____ **Other** (Please list) _____