Date _____ (PLEASE PRINT) Home Phone (____)_____

– Patient Information –

Name _____ (Last Name / First Name / Middle Initial) SS/HIC/Patient ID # _____

Address _____ Cell Phone (____)_____

City _____ State _____ Zip_____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Minor ☐ Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____)_____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

– Primary Insurance –

Person Responsible for Account _____ (Last Name / First Name / Middle Initial)

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's)_____ Phone (____)_____

City _____ State _____ Zip _____

Person Responsible Employed by_____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company_____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

– Additional Insurance –

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to Patient _____ Birthdate_____

Address (If different from patient's)_____ Phone (____)_____

City _____ State _____ Zip _____

Subscriber Employed by_____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan_____

– Assignment and Release –

I certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of Insurance Company(ies)) and assign directly to Dr. ADVANCE REHAB all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ Signature of Patient, Parent, Guardian or Personal Representative

_____ Date

_____ Please print name of Patient, Parent, Guardian or Personal Representative

_____ Relationship to Patient

– Registration Form –

Advance Rehab

2316 W. 23rd Street Suite B
Panama City, FL 32405
Ph: 850-522-4770 Fx: 850-522-4760

PATIENT MEDICAL HISTORY

Name:_____ Referring Doctor:_____

Date of injury **or** onset of symptoms:_____

Body part(s) injured **or** effected: _____

Briefly describe how the injury/accident/symptoms occurred:_____

_____

Pain on a scale of 1-10 (Best = 1 Worst = 10): Current: _____ Best: _____ Worst: _____ At Night? Yes / No

Date of initial doctor visit after injury:_____ Surgery(s) for this injury: 0 1 2 3 4+

Other surgeries and dates:_____

Prescription medication you are currently taking:_____

_____

Allergies to medications:_____

Which of the following doctors or treatment providers have you seen regarding this injury?

	YES	NO
General practitioner	_____	_____
Orthopedist	_____	_____
Neurologist	_____	_____
Physical Therapist	_____	_____
Chiropractor	_____	_____
Acupuncturist	_____	_____
Massage Therapist	_____	_____

Diagnostic Tests:	YES	NO
MRI	_____	_____
XRay	_____	_____
CT Scan	_____	_____

Other:_____

PLEASE MARK ANY OF THE FOLLOWING THAT APPLIES TO YOUR SIGNIFICANT MEDICAL HISTORY FOR APPROPRIATE CARE(PLEASE LIST TYPE FOR ANY DISORDER):

Cancer Type:	High Blood Pressure	Diabetes Type I or II:	Heart Disorder Type:	Lung Disorder Type:
Arthritis:	Pacemaker	Pins/Metal Implants Where?	Joint Replacement Joint:	Liver Disorder Type:
Blood Disorder Type:	Bladder Disorder Type:	Psych Disorder Type:	Sleeping Disorder Type:	Circulation Disorder Type:
Seizures	Stomach/Ulcers	Infection Problems	Head Injury Type:	Multiple Sclerosis
Parkinson's Disease	Stroke/TIA	Fractures	Frequent Headaches	Numbness/Tingling
Weakness	Loss Of Balance	Hearing Disorder Type:	Vision Disorder Type:	Osteoporosis
Tuberculosis	Hepatitis	Weight Loss OR Gain	Pain At Night Frequency:	Hernia
Varicose Veins	Kidney Disorder Type:	Smoker	Pregnant	Other

Goals/expectations while attending physical therapy:_____

_____

ADVANCE REHAB

2316 W. 23RD STREET, SUITE B
PANAMA CITY FL, 32405

PHONE: (850) 522-4770
FAX: (850) 522-4760

PLEASE INITIAL EACH LINE:

_____ I acknowledge I am currently not receiving home health care.

_____ I acknowledge my injury is not related to an auto accident which currently has an open case either with the auto insurance or an attorney. If my injury is related, I have notified the office of all current insurance information/attorney information to bill.

_____ I acknowledge my injury is not related to a work related accident, to which a workers comp claim has been filed. If my injury is related, I have notified the office of all current insurance information/attorney information to bill.

_____ I acknowledge I have listed all current insurances to be billed on the first page of this packet. I agree that if any insurance changes throughout the course of my treatment, I will notify the front desk immediately. **Failure to do so will result in the patient being responsible for any charges for services rendered.**

_____ Changes requiring notification at any time during your treatment are (**but not limited to**):

- New insurance company
- New insurance policy/ID number
- If you were involved in an auto accident
- If you were involved in a work related injury

Name: _____ DOB: _____

Signature: _____ Date: _____

Advance Rehab – Main Office
2316 W. 23rd Street Suite B
Panama City, FL 32405
Ph: 850-522-4770 Fax: 850-522-4760

INFORMED CONSENT

Conditions & Consent for Therapy Services / Financial Agreement / HIPPA Form

I understand that I am a patient of Advance Rehab & Home Health LLC, a private, therapist owned Physical, Occupational, Speech and Massage Therapy practice.

Cooperation with Treatment: In order for Therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the home Therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my Therapist.

Cancellation Policy: I understand that to successfully achieve the goals of treatment established by myself and my therapist, it is essential for consistent attendance as outlined by my plan of care. I understand that three (3) no shows could result in my discharge from therapy. Furthermore, I understand that if I cancel more than 12 hours in advance, I will not be charged. **I understand that if I cancel in less than 12 hours in advance, I will pay a cancellation fee of $30.00 to be paid at the time of my next appointment.**

Limitations: I understand that there are no guarantees regarding a cure for, or improvement in my condition. I understand that my Therapist will outline and discuss goals of therapy treatment for my condition and will discuss treatment options with me before I consent to treatment. There may be times where my insurance company will withhold payment for certain services rendered but care will be taken to inform me of such circumstances prior to rendered services.

Informed Consent for Treatment: I understand the term "Informed Consent" means that the potential risks, benefits and alternatives of therapy treatment have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

Potential Risks: I understand I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my therapist.

Potential Benefits: I understand I may experience an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increased strength, awareness, flexibility, and endurance in my movements. I may experience decreased pain and discomfort. I can expect to gain a greater knowledge about managing my condition and the resources available to me.

Alternatives: I understand that if I do not wish to participate in the therapy program, I will discuss my medical, surgical, or pharmacological alternatives with my physician or primary care provider.

Financial and Insurance Responsibilities: I understand it is my responsibility to call my insurance company ahead of time to obtain any pre-authorization that is necessary, and to obtain verification of my outpatient therapy benefits. I understand Advance Rehab & Home Health LLC will call my insurance carrier as a courtesy for me but ultimately it is my responsibility to verify the information Advance Rehab & Home Health LLC receives is accurate. If I have any questions regarding my insurance coverage, I understand that I can ask my insurance carrier, my therapist, or Advance Rehab & Home Health LLC for further assistance. **I am financially responsible for all charges whether or not paid by insurance at any time now, or up to 7 (seven) years after treatment.**

Notice of Privacy Policies: I understand that I was provided with a copy of the Notice of Privacy Policies utilized by Advance Rehab & Home Health LLC in compliance with regulations under the Health Insurance Portability and Accountability Act (HIPPA) Sec. 45 CFR 160 and 164. I understand that if I would like more information about Advance Rehab & Home Health LLC's privacy practices or to file a complaint, I can contact Advance Rehab & Home Health LLC, ATTN: Privacy Officer, 2316 W. 23rd Str., Panama City, FL 32405.

I have read the above information and I consent to the Therapy Evaluation and all subsequent treatment.

_____

Print Name Date

_____

Patient/Parent Signature (Guardian if patient is under 18 years of age)

ADVANCE REHAB

2316 W. 23RD STREET, SUITE B
PANAMA CITY FL, 32405

PHONE: (850) 522-4770
FAX: (850) 522-4760

NOTICE OF FEE

Please be advised that when you make an appointment for treatment, we are expecting that you **arrive on time** for the day you are scheduled. If for any reason you are unable to come to your scheduled appointment, please call the office **24 hours in advance** and advise us to cancel your appointment and reschedule if necessary.

If you do not call and cancel/reschedule your appointment **24 hours in advance**, there will be a fee in the amount of $30.00 that you will be required to pay before your next visit. **No exceptions!** This fee is necessary to decrease the amount of No Show/No Call appointments. To ensure that you are not charged, please make sure that you call the office to cancel or reschedule any appointments within the appropriate time frame.

By signing below, it states that you have read this notice and are aware of the fee. We thank you for your business and hope that we will be able to help you with your therapy needs.

_____ _____

Patient Signature **Date**

_____

Patient Printed Name

INSTRUCTIONS

Indicate where your pain is located and what type of pain you feel at the present time. Use the symbols below to describe your pain. Do not indicate areas of pain which are not related to your present injury or condition.

Key

/// Stabbing	XXX Burning	000 Pins and Needles	= = = Numbness