ADVANCE REHAB
2316 West 23rd Street, Suite B
Panama City, Florida 32405
850-522-4770 Fax 850-522-4760
850-249-5336 Beach Location

REGISTRATION FORM

(Please Print)

Date _____ Cell Phone (____) _____

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____
Address _____ Alt. Phone ( ) _____
City _____ State _____ Zip Code _____
Gender _____ Male _____ Female Age _____ Birthday _____
_____ Married _____ Widowed
_____ Single _____ Minor _____ Divorced _____
Separated _____ 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 (____) _____

ADDITIONAL INFORMATION

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)
and assign directly to ADVANCE REHAB & HOME HEALTH LLC. 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 submissions.

The above-named facility 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

PATIENT MEDICAL HISTORY

Name: _____ Referring Physician _____

Date of injury or onset of symptoms:
_____

Body part(s) injury or effected: _____

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

Pain on a scale of 0-10 (Best = 0 Worst = 10): Current Pain: ____Worst Pain: ____ Best Pain: ___ Pain 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?

General Practitioner	_____	_____	Diagnostic Tests:	YES	NO
Orthopedist	_____	_____	MRI	_____	_____
Neurologist	_____	_____	X-Ray	_____	_____
Physical/Occupational Therapist	_____	_____	CT Scan	_____	_____
Chiropractor	_____	_____			
Acupuncturist	_____	_____	Other: _____		
Massage Therapist	_____	_____			

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

Cancer Type:	High Blood Pressure	Diabetes Type I Type II	Heart Disorders Type:	Lung Disorder Type:
Arthritis Type:	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	Multiple Sclerosis
Parkinson's Disease	Stroke/TIA	Fracture	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 Weeks:	Other

Goals/expectations while attending therapy:

_____

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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, Aquatic and Massage Therapy practice.

Cooperation with Treatment: In order for therapy treatment to be effective, I must come to schedule 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) consecutive no shows could result in my discharge from therapy and ***I understand a $35 No Show fee will be charged***. Furthermore, I understand that if I cancel more than 24 hours in advance, I will not be charged. ***I understand that if I cancel in less than 24 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 Risk: 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 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 seven (7) 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 LOC, ATTN: Privacy Officer, 2316 W. 23rd Street, 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)	

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ACKNOWLEDGMENT

***** PLEASE INITIAL EACH LINE *****

_____ I acknowledge I am not receiving home health care.

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

_____ I acknowledge my injury **IS/ IS NOT** related to a work injury, to which a worker's comp claim has been filed. **If my injury IS related, I have notified this office of all current insurance information/attorney information.**

_____ I acknowledge I have listed all current insurance information 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 and all 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

_____	_____
Print Name	DOB

Signature _____ Date _____

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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 as needed.

If you do not call and cancel/reschedule your appointment ***24 hours in advance***, there will be a fee in the amount of ***$35.00*** that you will be required to pay on or 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 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.

_____
Print Name

_____ _____
Patient Signature Date

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INFORMATION RELEASE AUTHORIZATION

I hereby consent to the release and disclosure of my personal health information to:

DR.: _____

DR.: _____

DR.: _____

Advance Rehab & Home Health LLC

Insurance Company: _____

Insurance Company: _____

For the following purposes:

- My injury and all progress and associated issues
- Billing and reimbursement issues

I understand the information outlined in this release will be disclosed to according to the instructions of the release within two (2) business days of **Advance Rehab & Home Health LLC** having received this release authorization. I understand that I am free to revoke this release authorization at any time by notifying the facility in writing. I also understand that the information disclosed under this release is subject to re-disclosure and no longer protected by the Privacy Regulations (45 CFR 164).

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

Patient Signature Date

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: Use the symbols next to the words below to mark the figures

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